SAINT COLUMBKILLE SCHOOL

A TRADITION OF EXCELLENCE

SPIRIT • SCHOLARSHIP • SERVICE

6740 Broadview Road   Parma, OH 44134   216.524.4816
www.stcolumbkilleschool.org

Physician and Parent Request for Administration of Medication by School Personnel

Name of Student: ____

Address: ____
Street   City   Zip

Name of medication and dosage: ____

Times of day medication is to be administered: ____________________________________

Number of times/intervals medication is to be administered: ___________________________

Date administration is to begin: _____________________**Date to end medication:** ________________

Adverse or severe reaction that should be reported to the physician: __________________________

Special instructions for administration of medication: ______________________________________

This medication can be safely administered by non-medical personnel: ___ Yes   ___ No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours   ___Yes   ___No

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

Physician's Name: ____ **Phone #:** (____) ______________
(Please print)

Date: ____________ **Physician's Signature:** ____

Please regard my signature below as my assurance that I release St. Columbkille School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

Parent Name____**Phone #** (___) ________________
(Please print)

Parent signature____**Date:**______________

One Medication per Form

July 16