PHYSICIAN'S STATEMENT REGARDING ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL AND/OR SELF-ADMINISTRATION BY STUDENT

ST. MARY'S SCHOOL
2016 - 2017

PLEASE SCHEDULE MEDICATION OUTSIDE OF SCHOOL HOURS WHENEVER POSSIBLE

NAME OF STUDENT _____ **GRADE** _____

ADDRESS _____**TELEPHONE** _____

CONDITION FOR WHICH MEDICATION IS TO BE GIVEN _____

NAME OF MEDICATION _____

METHOD OF ADMINISTRATION: ORAL_____ **INHALER**_____ **INJECTION**_____**OTHER**_____

DOSAGE _____ **FREQUENCY** _____

THE MEDICATION IS TO BE CONTINUED AS ABOVE UNTIL _____

PRECAUTIONS ADVISED _____

POSSIBLE REACTIONS TO MEDICATION _____

ACTIONS TO BE TAKEN IN CASE OF REACTION TO MEDICATION_____

PHYSICIAN SIGNATURE **DATE**

PRINT NAME, ADDRESS & TELEPHONE OF PHYSICIAN

_____

_____

_____

MEDICAL SUPERVISION ADMINISTRATION OF MEDICINES

ST. MARY'S SCHOOL

2016 -2017

STUDENT INFORMATION

Last Name	First Name	Middle
Grade	Homeroom Teacher	Date of Birth

Medical Supervision/Administration of Medicines: I understand that the school is not legally obligated to store or administer medication for students and will not do so, either on a temporary or ongoing basis, except by special agreement. If I have indicated, by signing this paragraph below, that the school may administer **epinephrine injection (Epi-Pen)** to my child, and if the school has agreed to administer **epinephrine injection (Epi-Pen)** by signing this paragraph below, I authorize the school to administer the **epinephrine injection (Epi-Pen)** listed on this form, as indicated, but recognize that the school does not thereby undertake any ongoing duty to administer drugs or medicine, or to supervise or participate in any self-medication or medical program or ongoing, routine or non-emergency needs of my child, all of which remain my responsibility. Before any medication is given by the school, I will provide those medications in their original pharmacy containers, with the child's name and doctor's instructions on the label, and I will provide a written, signed authorization from a physician, including complete instructions.

Medication to be Self-Administered by the Child (for existing conditions/physician's note required): _____

_____

Dosage_____ **Frequency** _____

Medication to be Administered by a Trained School Employee: _____

Dosage _____ **Frequency** _____

NOTE: ALL MEDICINES TO BE TAKEN ON SCHOOL GROUNDS, WHETHER SELF-ADMINISTERED OR ADMINISTERED BY THE SCHOOL (IF SCHOOL AGREES TO DO SO), MUST BE ARRANGED FOR IN ADVANCE, AND MUST BE PROVIDED IN THEIR ORIGINAL PHARMACY CONTAINER, INCLUDING THE CHILD'S NAME AND DOCTOR'S INSTRUCTIONS.

THE SCHOOL WILL NOT ADMINISTER MEDICINES UNLESS A PHYSICIAN'S WRITTEN AND SIGNED AUTHORIZATION, INCLUDING COMPLETE INSTRUCTIONS, IS ATTACHED TO THIS FORM.

In consideration of the arrangement indicated in this paragraph, the undersigned hereby releases and discharges the Diocese of San Jose, its constituent organizations, including but not limited to the Roman Catholic Welfare Corporation, the Department of Education and St. Mary's School, and their respective officers, agents, and employees (the "Diocese") for any and all claims for personal injuries or property damage that I or my child may suffer as a result of this arrangement whether or not such injuries or damages be caused by the negligence (whether active or passive) of any of the entities or individuals named or described above, excepting only injuries or damage resulting from Diocese's willful misconduct. I authorize and request the school to administer the above medications to my child on these terms.

Signature of Parent/Legal Guardian	Date

On behalf of the School, I agree to supervise administration of the above medications, consistent with the terms contained herein.

Signature of School Principal	Date

MEDICAL SUPERVISION
ADMINISTRATION OF MEDICINES
ST. MARY'S SCHOOL
2016 - 2017

1. General Terms of Parental Consent

CONFIDENTAL MEDICAL OR EDUCATIONAL INFORMATION AS SET FORTH IN THIS FORM WILL BE GATHERED, USED AND DISSEMINATED ONLY BY THE PERSONS AND ONLY FOR THE PURPOSES SET FORTH HEREIN, OR AS OTHERWISE ALLOWED BY LAW.

THIS AUTHORIZATION IS EFFECTIVE ONLY FOR THE SCHOOL YEAR LISTED ABOVE, AND WILL EXPIRE ON JUNE 15 OF EACH SCHOOL YEAR. IT MAY BE REVOKED AT ANY TIME IN WRITING, SIGNED BY EITHER PARTY. IF REVOKED, THE SCHOOL RESERVES THE RIGHT TO SUSPEND OR TERMINATE THE ATTENDANCE OF THE CHILD AT THE SCHOOL.

I AGREE TO AND CONSENT TO THE ACTIONS SET FORTH HEREIN AND HEREBY GRANT AUTHORIZATION OF THE SCHOOL TO OBTAIN AND USE MEDICAL INFORMATION AND RECORDS BY THE PERSONS, FOR THE PURPOSES, AND DURING THE TIME SET FORTH ABOVE.

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A TRUE COPY OF THIS AUTHORIZATION. BY MY SIGNATURE, I ACKNOWLEDGE THAT A TRUE COPY OF THIS AUTHORIZATION HAS BEEN RECEIVED BY ME.

Signature Print Name Date

Relationship to Above-Named Child: _____

Signature Print Name Date

Relationship to Above-Named Child: _____