PARENT/GUARDIAN MEDICATION REQUEST FORM

Prescription drugs and over-the-counter medication should, whenever possible, be dispensed by a parent or guardian. If a child is given a prescription or medicine to "take 3 times daily," recommend to the parent that it be given to the child before he or she comes to school, after going home from school, and before bedtime.

Only when dispensing is required more often, or with lunch, should the school be involved with dispensing.

Any prescription or over-the-counter medicine must be in the **original, labeled container** and stored under lock and key.

The following information must be completed **before** medicine is given.
(PLEASE PRINT)

Full name of Child to be medicated: _____

Name of Drug and Dosage: _____

Hour(s) Medication to be given: _____ # of Days: _____

Physician Prescribing Medication: _____
*(**only** if prescription medication)*

Physician's Phone Number: _____
*(**only** if prescription medication)*

Reason for Medication: _____

I hereby give permission for school personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician.

I agree to hold Assumption of the Blessed Virgin Mary School; and the Catholic Diocese of Green Bay, its employees, and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

_____ _____
Signature of Parent/Legal Guardian Date

NOTE: Before a prescribed medication(s) will be administered by the school or an agent thereof, the **attached Physician's Request for Medication Administration** form shall be completed and returned to the School Principal or School Nurse.

This form (Parent/Guardian Medication Request) must also be completed for the administration of non-prescription (over-the-counter) medications.

Physician's Request for Medication Administration ~ *Please print*
Assumption B.V.M. Parish Office Fax Number **920-822-8030**

To: **Assumption B.V.M. School** Effective Date: _____

Name of Student: _____ Grade: _____

Address: _____

Phone Number: _____

Physician's Name: _____ Phone: _____

Physician's Address/Clinic: _____

Reason for Medication: _____

Medication/Dose/Route/Frequency/Duration: _____

Check one: _____ Short-term _____ Long-term

PRN (As the situation demands) Medications: _____

Medication/Dose/Route/Frequency/Duration: _____

Medication/Dose/Route/Frequency/Duration: _____

If a PRN Medication, state condition under which medication is to be given:

_____

Check one: _____ Short-term _____ Long-term

State the specific conditions under which contact should be made with you in relation to the conditions or reactions of the student receiving the medication.

_____

NOTE: Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by the non-medically trained designees specified on this form, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

_____ _____

Signature of Physician Date