# St. Stanislaus School Medication Administration Consent Form

1861 136th Avenue, Dorr, MI 49323 Phone (269)793-7204 Fax (269)793-3264

Medication (both prescription and over the counter) may be administered at school by school personnel when necessary for school attendance. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

*As a parent, I understand my responsibilities are:*

1. *To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school).*
2. *To provide the school with the written doctor's instructions for medication administration during school hours.*
3. *To inform the school of any medication and/or medical changes.*

Medication means: "any prescription or over the counter medication. This includes, but is not limited to: vitamins and food supplements; eye, ear and nose drops; inhalants; medicated ointments or lotions; aspirins; cough drops; antacids."

Student: ______________________________ Birthdate: __________ School Year: ________

Parent/Guardian Name: ________________________________ Phone Number: ____________

Doctor's Name: ______________________________ Dr. Phone Number: __________

Doctor's Address: ____________________________________________________________

I, ____________________________, ________________________ of ______________________
(Name) (Relationship) (Student)
do hereby request that the building administrator or administrator designee, administer the (prescribed) medication listed below as directed.

This also authorizes an exchange of information, as necessary, between the school and my child's health care provider.

Signature of Parent/Guardian: ___________________________________ Date: _________

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*To be completed by the Physician*

Reason / Condition for medication: _____________________________________________

Name of Medication: ___________________________________________________________

Dosage: ________________ Time during school: ________________

Restrictions / and or side effects: ☐ none anticipate ☐ Yes

Please describe: ______________________________________________________________

______________________________________________________________________________

This student is both capable and responsible for self-administering this medication: ☐ Yes ☐ No

May the child omit this medication during a field trip? : ☐ Yes ☐ No

______________________________ ______________________________
Physician's Name (print) Physician's Signature

______________________________________________________________________________
Physician's Address

Phone: __________________ Fax: ___________________ Date: _________________
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