

CATHOLIC SCHOOLS-DIOCESE OF DALLAS
REQUEST FOR IN-SCHOOL ADMINISTRATION OF MEDICATION (HF-7,0)

NOTE TO PARENTS/GUARDIANS:

Clinic personnel are not permitted to give medication of any kind, prescription and non-prescription, unless the physician requests in writing that there is a need for such medication. The doctor's statement must be accompanied by written permission of at least one parent.

To the Principal of St Joseph Catholic School Date _____

Name of School Child _____ **Birthdate** _____

In order to keep this school child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours.

Name of Medication _____ Reason Medication Given _____

Form of Medication to be given is circled below:

Tablet Pill Capsule Liquid Inhalent

Other (specify): _____

Dosage (amount to be given): _____

How often or at what time: _____

Date Discontinued: _____

Physician's signature: _____

Phone No. _____

I agree to hold the school harmless for the proper administration of medication provided by the parent/guardian and for adverse drug reactions or side effects.

I agree to be responsible for maintaining an adequate supply of medication at the school to meet the child's need.

Parent/Guardian _____

Work no. _____ Home no. _____