

Medication Form (2017-2018)
ONE FORM PER CHILD – KINDERGARTEN THROUGH 8TH GRADE

Medication is given at school only upon written request from parent/guardian and the licensed physician who is prescribing the medication. These written requests are required before administration of any medication is initiated. School personnel will not be responsible for administering injectable medications. **Please provide all requested information.**

Student Name: _____ Date of Birth: _____ Grade: _____

The above named student needs to receive the following medication during his/her regular school attendance time:

Medication: _____ Dosage: _____

Requested Starting Date: _____ Expected Duration: _____

School time schedule of administration: _____

Diagnosis/ Other pertinent information: _____

Physician's signature: _____ Date: _____

I hereby certify that _____ has previously had at least one dose of the above prescribed medication and did not have an adverse reaction from it. I request that this medication be administered at school as directed above. I understand that any school employee who administers this prescription to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug or because of mislabeled or altered product.

I hereby authorize John Paul II Catholic School personnel to exchange information regarding this request with _____, the above named attending physician and with the pharmacy as identified on the affixed pharmacy label.

OVER THE COUNTER MEDICINE DOES NOT REQUIRE A PHYSICIAN'S SIGNATURE

Parents must furnish this medicine with the child's name on the label, in its original container and directions for dosage and frequency.

My child may take (check appropriate space):

- | | |
|--|--|
| <input type="checkbox"/> Sunscreen | <input type="checkbox"/> Hydrogen peroxide (to clean wounds) |
| <input type="checkbox"/> Ibuprofen (Advil) | <input type="checkbox"/> Neosporin/Bacitracin (topical ointment used for minor cuts, scratches, burns) |
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Hydrocortisone/Benadryl Cream (topical cream for itches and rashes) |
| <input type="checkbox"/> Cough Drops | |
| <input type="checkbox"/> Tums/Mylanta | |
| <input type="checkbox"/> Allergy Eye Drops | |

Parent/Guardian printed name: _____

Parent/Guardian signature: _____ Date: _____