JOHN PAUL II
CATHOLIC SCHOOL
6915 W. 71st St., Overland Park, KS 66204

School: 913-432-6350
Preschool: 913-432-6419
johnpaul2@archkckcs.org
www.johnpaul2opks.com

Medication Form (2019–2020)

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):

_____ Sunscreen
_____ Ibuprofen (Advil)
_____ Acetaminophen (Tylenol)
_____ Cough Drops
_____ Tums/Mylanta
_____ Allergy Eye Drops
_____ Hydrogen peroxide (to clean wounds)
_____ Neosporin/Bacitracin (topical ointment used for minor cuts, scratches, burns)
_____ Hydrocortisone/Benadryl Cream (topical cream for itches and rashes)

Parent/Guardian printed name: ____

Parent/Guardian signature: ____ Date: ________________