SCOTUS CENTRAL CATHOLIC

AUTHORIZATION TO MEDICATE/TREAT FORM

Medication is administered at school by school personnel when such treatment is necessary for school attendance and cannot otherwise be accomplished. This completed form along with the medication must be brought to the school by the parent or student for whom the medication is prescribed. All prescription medications are locked in and dispensed from the Front Office.

Prescribed medication/treatment is administered by a school nurse/authorized personnel. Prescription medications **MUST** be brought to the school in the **original container appropriately labeled by the pharmacy**. Parents may request the pharmacist dispense two (2) bottles of medication, one for home and one for school. All non-prescription medications such as aspirin, ibuprofen and acetaminophen also **MUST be in original containers**.

Prescribed asthma inhalers may be kept by the student and self-administered when the physician indicates the need in writing and considers the student sufficiently responsible. In addition, the physician should list any precautions to be followed on this form so the school nurse/designated person can inform the principal and other appropriate parties.

Student Name: _____ Grade: _____

Allergies: _____

Name of Medication: _____ Dosage: _____

Reason for Medication: _____

Form of Medication: _____Tablet/Capsule _____Liquid _____Inhaler _____Injection

_____Nebulizer _____Other: (please list)_____

Instructions/Time and Dosage to be given at School: _____

Restrictions/Side Effects: _____No _____YES (please list) _____

Special Storage Requirements: _____None _____Refrigeration necessary

Special Administration Procedures: _____None _____Crush pill _____With food

Prescribing Doctor: _____

I, the parent/guardian of _____, request the above documented medication/procedure be administered to my child as prescribed. I absolve school personnel and the school district from liability stemming from any and/or all adverse reactions/effects that may occur as a result of administering the prescribed medication/ procedure.

Printed Name: _____ Relationship: _____

Telephone: (Home)_____(Work)_____(Cell)_____

Parent/Guardian Signature: _____

Date Form Received by the School and Staff Initials: _____