# ST. JOSEPH'S SCHOOL
# MEDICATION REQUEST FORM

| Student Name | Grade | Birthdate | School | Date Today |
|---|---|---|---|---|
| | | ___/___/___ | | |

SCHOOL MEDICATION AND HEALTH CARE SERVICES ARE ADMINISTERED FOLLOWING THESE GUIDELINES:

- Parent signed and dated authorization to administer the medication.
- Medication in the pharmacy labeled container or the manufacturer's labeled container.
- Medication label contains the student name, medication, directions for use and date.
- Annual renewal of authorization and immediate notification in writing of any changes.

| Medication / Health Care | Dosage | Route | Time Given At School |
|---|---|---|---|
| | | | |

Administration Instructions

Diagnosis

___ STUDENT IS KNOWLEDGEABLE ABOUT THIS MEDICATION AND MAY SELF-ADMINISTER.

Licenced Prescriber Signature — Date

Licenced Prescriber Address — Emergency Phone Number

PARENT PORTION BELOW

I request this student be given the medication at school and school activities by qualified staff according to instructions. The student has experienced no serious previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know. I agree to provide safe delivery of medication to and from school, and pick up remaining medication or it will be properly destroyed. All students are responsible to report to the health office for medication unless self-medication is recommended.

Parent/Guardian Signature — Date

Home Address — Home Phone Number

Business Address — Business Phone Number

Additional Information