Request for Administration of Non-Prescription Medication by School Personnel

(not to be used for Epinephrine or Inhalers)

Student's name: _____ **Birthdate:** _____ **School/Grade/Teacher:** _____

- Parent/guardian must complete and sign this form each school year.
- This completed form must be on file in the student's health record before prescription medication will be administered by school personnel. A separate form is required for each individual medication.
- Medication must be in the original container as dispensed by the physician, pharmacist, or manufacturer and will be stored in the school clinic.

Medication name and strength	
Dose	
Route	
Time (during school or school activity)	
Severe adverse reactions to be reported to prescriber	
Special instructions for administration	
Possible side effects	
Special storage instructions	
Starting & ending date of this request	Start _____ End _____

I. Parent/Guardian's Section

I hereby request and give my permission for St. Brigid personnel to administer this over the counter medication to my child. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued.

I agree to submit a revised Medication Administration form if any changes are made regarding the above medication.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____