MEDICAL FORM FOR ADMINISTRATION OF MEDICATION AND SELF MEDICATION ADMINISTRATION

THIS FORM IS GOOD FOR UP TO ONE SCHOOL YEAR ONLY

The following is to be completed by a licensed health care provider. No medication of any kind will be given to your child until this information is completed and returned to school. The parent/guardian may complete the health-care provider section for non-prescription medication.

- All medication must be in a **pharmacy-labeled container**. **NOTE:** Over the counter medication must be brought to school in an unopened original container.
- If any changes in medication occur during the school year, a new form must be completed along with a new pharmacy-labeled container and returned to the school.
- **Only one form for each medication is to be used**.
- Medication must be brought to school by a responsible adult. Please **do not send medication by children**.
- Any unused medications will be destroyed at the end of the current school year if not retrieved by the parent/guardian.

TO BE COMPLETED BY PARENT:

Name of student ______________________________ Date of Birth ______________

School _____St. Benedict at Auburndale High School______________________ Grade ___________

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School and its employees and agents, on my behalf to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the School), lawfully prescribed medication in the manner described. ***I acknowledge that it my be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices****, I agree to indemnify and hold harmless the School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.*

______________________ ______________________ ______________

Parent /Guardian (Please Print) Parent/Guardian Signature Date

Mother's Cell Phone______________________ Father's Cell Phone______________________

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Emergency Contact (Name and Phone)

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY:

Diagnosis for which medication is given ______________________________

Name of medication______________________ Dosage ______________________

Start Date______________________ Stop Date______________________

Form _________ Route________ Special Handling Instructions: ______________________

If medication is to be given daily, at what time(s)? ______________________

Dates must be administered at school:

☐ Every day at school ☐ As needed only

If medication is to be given "when needed," describe symptoms student will exhibit. ______________________

______________________________ How soon can it be repeated? ____________

Possible side effects, if any ______________________________

Healthcare Provider Name (**Print**) ______________________________

Healthcare Provider Signature ______________________________ Date ___________

Address ______________________________ Zip Code ____________

Phone ______________________ Fax ______________________

(School Staff Only) Completed form received on ______________ ***By*** ______________

Date Signature