



Health Services Program

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

To Parents or Guardians:

To request that Saint John's Catholic Prep administer medication to your child at school, the following is required:

- The medication is furnished by the parent(s) or guardian(s) in a container labeled by the pharmacist or physician with:
 - The name of the child -The name of the medication -Conditions for proper storage
 - The name of the physician -Dosage, route, and time -Prescription/Expiration dates
- The Covenant not to Sue and Indemnification Agreement is signed by both parents or guardians.

I/We _____, being over 21 years of age, parents/guardians of _____, a minor of _____ years of age, in accordance with physicians order (below) on file with Saint John's Catholic Prep, its agents, servants and employees, promise that neither said minor nor we, individually or as parents or guardians of said minor, will ever institute any suit for damages, loss or injury either to person or property of both, whether developed or undeveloped, resulting or to result, known or unknown, which said minor or we individually, or as parents or guardians of said minor, now have or which we, our or his heirs, executors or administrators, hereafter can, shall or may have for, on or by any reason of any matter, cause or thing whatsoever.

And in further consideration of said services made to us, individually and on behalf of said minor, we hereby agree to indemnify and save harmless Saint John's Catholic Prep, its agents, servants and employees against any claim for damages, compensation or otherwise on the part of said minor or his heirs, executors or administrators and to reimburse or make good any loss or damages or costs that they may have to pay if any litigation arises on account of any claims made by said minor or anyone on his/her behalf.

Signature: Parent/Guardian _____ & Parent/Guardian _____

- The child's physician must complete the Physician's Signed Order below.

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL

Name of Student: _____ (Last) _____ (First) _____ (M.I.) DOB: ____/____/____

Diagnosis: _____

Name of Medication: _____

Dosage: _____ (mg, ml, ml/tsp, # of puffs)

Route: _____ Time of Administration at School: _____

If PRN, for what symptoms? _____ How Often? _____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

Services should begin (Date) _____ and terminate (Date) _____

FOR INHALER AND EPI-PEN MEDICATION ONLY:

____ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used.

____ This student should not self-administer inhalant medication or Epi-pen.

Physician's Signature: _____ Physician's Name (Printed): _____

Address: _____

Telephone Number: _____ Date: _____

- I/We assure that the first dose of this medication has been given without problems and having read the above conditions, we request that Saint John's Catholic Prep administer the medication as prescribed by Physician above to our son/daughter _____.

School Child Attends: _____

Signature: Parent/Guardian: _____ & Parent/Guardian: _____

Parent's Telephone Number: _____