St. Vincent Pallotti High School

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

To Parents or Guardians:

To request that St. Vincent Pallotti High School administer medication to your child at school, the following is required:

- The medication is furnished by the parent(s) or guardian 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 date and expiration date.

- The Covenant not to Sue and Indemnification Agreement is signed by both parents or guardians.

We, ________________________________, being over 21 years of age, parents and/or guardians of ______________________________, a minor of ______ years of age, in accordance with physicians order (below), on file with St. Vincent Pallotti High School, its agents, servants and employees, promise that neither said minor nor we, individual 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/her 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 St. Vincent Pallotti High School, its agents, servants and employees against any claim for damages, compensation or otherwise on the part of said minor or his/her 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.

In witness whereof, we hereunto set our hands and seals this ________ day of __________________, 2______.

Parent or Guardian: ________________________ / Parent or Guardian: ___________________________

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

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL

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

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 students is able to self-administer and carry inhalant medication or Epi-pen 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: ____________________________

- We assure that the first dose of this medication has been given without problems and having read the above conditions, we request that St. Vincent Pallotti High School personnel administer the medication as prescribed by Physician above to our child, ____.

Parent or Guardian: ______________________________ / Parent or Guardian: ____________________

Both parents must sign or indicate the reason a signature is not available (such as deceased parent).

Parent's Telephone Number(s): ____

(see reverse side)

Authorization and Permission for Administration of Medication

Student's Name (Last) (First) (Middle) ___ Birthday / / ___ School ___ Date ___

School medications and health care services are administered following these guidelines:

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

Medication/Health Care ___ Dosage ___ Route ___ Time at School ___

Administration instructions ___

___

Discontinue/Re-Evaluate/Follow-up Date ___

Prescriber ___ Date ___

Prescriber's Address ___ Emergency Phone ___

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced **no** 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 understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

Parent's Signature ___ Date ___

Parent's Address ___ Home Phone ___

Additional Information ___ Business Phone ___

___

___

___

(see reverse side)