

Medication Permission Form

Student \_\_\_\_\_ DOB \_\_\_\_\_
School \_\_\_\_\_ Grade \_\_\_\_\_

All medications whether prescribed by a physician or authorized prescriber or over-the-counter must have signed orders from the parent / guardian and the physician or authorized prescriber. Parent / guardian must bring medication to school office. The prescription or over-the-counter medication must be brought in the original container. For prescription medication, the label must match the physician’s or authorized prescriber instructions order. The physician or authorized prescriber instructions for the over-the-counter medication instruction must be within the instructions for use of the over-the-counter meditation.

To be completed by the Physician or Authorized Prescriber:

Reason for the medication: \_\_\_\_\_

Name and strength of medication: \_\_\_\_\_

Form Medication:

Tablet/capsule Liquid Inhaler Injection Other

Amount and Time/s: \_\_\_\_\_

For PRN state the frequency, the time between dosages of medication, and maximum number of doses in a school day: \_\_\_\_\_

Start date for medication: \_\_\_\_\_

End date for medication: \_\_\_\_\_ (All orders will be valid for the current school year.)

Additional information, instructions, restrictions, and/or important side effects: \_\_\_\_\_

Physician or Authorized Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician’s or Authorized Prescriber name (print):

Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax number \_\_\_\_\_

To be completed by the Parent / Guardian:

I instruct the school principal or the principal authorized personnel to give the medication as instructed above.

Do you want to be called before or after (circle) a PRN medication is given? Yes \_\_\_\_\_ No \_\_\_\_\_

Additional information / instructions, or restrictions \_\_\_\_\_

Consent

I hereby request that the medication specified above be given to the above named student. I understand that the school personnel who give the medication may not be a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school’s agreeing to allow the medication go be given is for my benefit and the student’s benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Diocese of Galveston-Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Diocese of Galveston-Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_ Relation to the child \_\_\_\_\_

Special forms are required for severe allergies and administration of Epipens, administration of diabetic medication, and self-administration and carrying of asthma medication.

Ref: American Academy of Pediatric

Diocese of Galveston-Houston Health Manual

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