MEDICATION PERMISSION FORM
Catholic Schools Office
Archdiocese of Galveston-Houston

Student_____ D.O.B._____

School _____Grade_____

Policy for students receiving medication at school whether prescribed medication or over the counter medication approved by a physician is as follows:

- Signed orders from the parent/guardian and physician must be on file
- All medication must be provided in the original container
- Prescribed medication with a pharmacy label that matches the written orders
- All medication must be provided to the school by the parent
- School personnel may refuse to give the medication
- A completed Medication Permission Form is approval for one academic school year

To be completed by the Parent/ Guardian

Does the parent want to be called before a PRN "as needed" medication is given? ❑ Yes ❑ No

Parental/Guardian Consent

I hereby request that the medication specified by the prescribing physician to 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 to 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 Archdiocese 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 Archdiocese 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 _____

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

To be completed by the Physician:

Type of Medication ❑ Prescription ❑ Non-Prescription		Name of Medication and Strength	
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
For **PRN** state the Frequency (time between dosages of medication and maximum number in a school day			
Reason medication being given			
Form of Medication ❑ Tablet ❑ Capsule ❑ Liquid ❑ Inhalant ❑ Injection ❑ Other _____			Route (ex: oral, nasal)
Physician's Signature	Physician's Printed Name	Office Phone	Date

For additional medications use back page.

To be completed by the Physician:

Type of Medication ❑ Prescription ❑ Non-Prescription	Name of Medication and Strength		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
For **PRN** state the Frequency (time between dosages of medication and maximum number in a school day			
Reason medication being given			
Form of Medication ❑ Tablet ❑ Capsule ❑ Liquid ❑ Inhalant ❑ Injection ❑Other ________________			Route (ex: oral, nasal)
Physician's Signature	Physician's Printed Name	Office Phone	Date

To be completed by the Physician:

Type of Medication ❑ Prescription ❑ Non-Prescription	Name of Medication and Strength		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
For **PRN** state the Frequency (time between dosages of medication and maximum number in a school day			
Reason medication being given			
Form of Medication ❑ Tablet ❑ Capsule ❑ Liquid ❑ Inhalant ❑ Injection ❑Other ________________			Route (ex: oral, nasal)
Physician's Signature	Physician's Printed Name	Office Phone	Date

To be completed by the Physician:

Type of Medication ❑ Prescription ❑ Non-Prescription	Name of Medication and Strength		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
For **PRN** state the Frequency (time between dosages of medication and maximum number in a school day			
Reason medication being given			
Form of Medication ❑ Tablet ❑ Capsule ❑ Liquid ❑ Inhalant ❑ Injection ❑Other ________________			Route (ex: oral, nasal)
Physician's Signature	Physician's Printed Name	Office Phone	Date