Holy Ghost School

ADMINISTRATION OF PRESCRIBED MEDICATIONS

PERSONAL INFORMATION

Name of student _____ Date of Birth _____

Address _____

Home telephone number _____

Health coverage registration numbers: Registration # (6 digits) _____

Child's Personal # (9 digits) _____

Parent/Guardian _____

Phone (Home) _____ (Business) _____

Parent/Guardian _____

Phone (Home) _____ (Business) _____

Prescribing physician _____

Office address _____

Office telephone number _____

Dispensing pharmacy _____

Address _____

Telephone number _____

MEDICATION INFORMATION

Name of medication _____

Reason for medication _____

_____

Dosage and method of administration (include time)

_____

_____

Start date of medication _____

Stop date of medication (if applicable) _____

First dose administered at home? Yes / No (Circle the appropriate response)

First dose well tolerated by student? Yes / No _____

Storage requirements (if necessary) _____

_____

Description of side effects _____

_____

_____

Response to side effects _____

_____

_____

I will send or deliver a sufficient supply of the medication to the school in the original pharmacist's labeled container. If I am unable to deliver it personally, it will be delivered as follows (name of person authorized, and the time(s) of delivery):

_____

_____

_____

AUTHORIZATION

I/We authorize the school to contact the doctor, or the dispensing pharmacist, for further information, and I authorize the doctor and/or pharmacist to release any further information requested by the school.

Signature of Parent / Guardian _____

RELEASE DECLARATION

I realize that the staff members who volunteer to assist my child in this way are not medical professionals. In consideration of their assistance, I RELEASE HOLY GHOST SCHOOL, AND ITS OFFICERS AND EMPLOYEES, FROM ANY LIABILITY ARISING FROM THE ADMINISTRATION OF PRESECRIBED MEDICATION TO MY CHILD IN ACCORDANCE WITH THE INSTRUCTIONS SET OUT IN THIS REQUEST.

Date: Signature of Parent (Guardian)

_____ _____

_____ _____