St. Patrick School

Administration of Medicine by School Personnel
2015-2016 School Year

This form is for all **Prescription** and **Non Prescription Medications.** We appreciate your help in scheduling medication outside of the school hours whenever possible. In addition, the *first dose* of any "first time" medication cannot be administered at school.

1. Name of pupil: _____ Date of Birth_____
2. Address: _____ Phone: _____
3. Condition for which medication is to be given: _____
4. **Name of Medication:** _____
5. **Method of Administration:**

   Oral _____ Inhaler _____ Injection _____ Other _____
6. **Dose:** _____ **Schedule of doses:** _____
7. The medication is to be continued as above until: _____
8. Medication precautions advised: _____
9. Possible reactions to medication: _____
10. Actions to be taken in case of reaction to medication:

    _____
11. Check one below:

    a. _____ I give this pupil permission to self-administer the above medication.

    b. _____ I authorize designated school personnel to administer the above medication.
12. Print name and phone of physician

    _____

A physician and parent signature is required to administer medication in the school setting.

_____ Parent Signature

_____ Physician Signature (Required)

Date: _____