

St. Patrick School

Administration of Medicine by School Personnel
2017-2018

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: _____