

**ST. JAMES ACADEMY HEALTH ROOM FORM
PRESCRIPTION MEDICATION*****

Consent for Medication to be administered During School Attendance

Name of Student: _____ Grade: _____

Medication* : _____

Start Date: _____ End Date (if applicable) _____

Other Medication taken at home (list ALL): _____

Medication Allergies: _____

* Once a day medication will not be given on a routine basis.

+++School Personnel must have parental consent and a physician's order to dispense prescription medication. The medication is to be brought to school in the original container appropriately labeled by the pharmacy stating child's name, physician's name, name of medication, dosage and Rx (prescription) number. (The Rx label IS acceptable as the doctor's order). If a change in type of drug or dosage is warranted, a new request signed by parent and physician must be provided. All medication will be maintained in the nurse's office and dispensed according to label instructions and the discretion of the school nurse.

IF IT IS NECESSARY FOR A STUDENT TO RETAIN POSSESSION OF MEDICATION (IE: INHALERS) THIS MUST BE DISCUSSED WITH THE SCHOOL NURSE, REQUESTED IN WRITING VIA THIS FORM AND APPROVED BY STUDENTS PHYSICIAN. WE FURTHER ASK THAT A DOSE OF THE MEDICATION BE PROVIDED FOR THE HEALTH ROOM IN CASE OF EMERGENCY.

CONSENT TO ADMINISTER MEDICATION

I hereby give permission for my above named child to be administered the following MEDICATION: _____ Is this a new Rx for your child? Yes___ No___

TIME AND DOSAGE OF MEDICATION: _____

STUDENT'S SIDE EFFECTS WITH THIS MEDICATION? _____

I understand that school personnel must have parent consent and a physician's order before prescription medication can be administered at school. I understand it is my responsibility to furnish this medication in its original container and proper instructions for administering the same. I further understand that any school personnel who will administer this medication in accordance with written instructions from a physician, dentist, or parent shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such a drug. The INITIAL dose of any prescribed medication will not be administered at school.

PARENT SIGNATURE

DATE

PHYSICIANS SIGNATURE (If no Rx bottle)

DATE