Medication Permission Form

Student____ DOB___________
School ____ Grade__________

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

- Signed orders from the parent/guardian and physician must be on file
- Over-the-counter medication brought in the original container
- Prescribed medication with a pharmacy label that matches the written orders
- All medication must be brought to the school by the parent
- School personnel may refuse to give the medication

To be completed by the Physician or Authorized Prescriber:
Reason for the medication: ____
Name and strength Medication: ____
Form Medication:

❑ Tablet/capsule	❑ Liquid	❑ Inhaler	❑ Injection	❑ Other

Amount and Time/s:

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For PRN state the frequency, the time between dosages of medication, and maximum number of dose in a school day: ______________________________________

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Start date for medication: _________________
End date for the medication: _________________ (All orders will be valid for the current school year.)
Additional information, instructions, restrictions and/or important side effects:

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Physician or Authorized Prescriber Signature __________________Date___________
Physician's or Authorized Prescriber name (print):Name _________________________
Phone Number _______________________ Fax number_______________________

To be completed by the Parent/ Guardian:
I instruct the school principal or the principal authorized personnel to give the medication as instructed above.
Do you want to be called before or after a PRN medication is given? Yes___ No____
Additional information/instructions or restrictions ______________________________

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Consent
I hereby request that the medication specified above 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 ___________
Printed name______________________________ Relation to the child ________
Special forms are required for severe allergies and administration of Epipens, administration of diabetic medication, and self-administration and carrying of asthma medication.