

THIS FORM IS TO BE RETURNED ONLY WHEN APPLICABLE

**St. Mary of the Assumption Catholic School
2024-25 REQUEST FOR ADMINISTRATION
OF MEDICATION BY SCHOOL PERSONNEL**

Written permission **must** be obtained from a physician before any prescribed and/or over-the-counter medication can be administered by school personnel during school hours. Parents' permission is also required. Medication must be in the original, labeled container. A parent or legal guardian must bring the medication to the school office. If you do not wish to have a physician complete this form, a parent or legal guardian may come to the school office during lunch or recess to administer the medication to the student. The school will not administer any prescription or non-prescription medication without this form. The only exceptions are ibuprofen/acetaminophen (school supplies) when verbal approval is obtained by school personnel every time the pain relief is requested. This means school personnel will call a parent/legal guardian for permission before ibuprofen or acetaminophen is given. If a parent or legal guardian cannot be reached, a pain reliever will not be given.

PHYSICIAN'S STATEMENT (to be completed by a physician):

_____ is under my care and should receive:

Name of drug, dosage and route

at the following times: _____

Beginning Date: _____

Ending Date: _____

Specific instruction for administration: _____

Possible side effects: _____

Date

Physician's Signature

Physician's Phone Number

PARENT'S STATEMENT:

In consideration for the overseeing and dispensing of medication for the child referenced on this form, I hereby release and discharge the Toledo Catholic/Private Schools, the Principal of the responsible school, his/her designees, and any other persons connected with the overseeing and dispensing of medication or drugs herein described, from all claims, demands, actions, judgments, and executions which may arise from the overseeing or dispensing of the medication. We (I) agree to notify the school personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician. The undersigned have read this form and understand all of its terms.

Parent/Guardian Name (please print)

Parent's Signature

Date