PHYSICIAN'S STATEMENT REGARDING PRESCRIBED MEDICINE

PLEASE SCHEDULE MEDICATION OUTSIDE OF THE SCHOOL HOURS WHENEVER POSSIBLE

Name of Pupil (First, MI, Last Name)	Date of Birth
Name(s) of Parents(s) or Guardian(s) (M) (F)	*Telephone* (M) (F)
Address (M) (F)	

Reason for medication:

Name of medication:

Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Other (Describe)

INSTRUCTIONS

Schedule and dose to be given at school:

The school strongly recommends and prefers that all medication should be in a pre-measured "Unit Dose" format.

☐ For episodic/emergency events only

Start: ☐ Date form received at school ☐ Other start date: _____

Stop: ☐ End of school year ☐ Other stop date/duration: _____

Restrictions and/or important side effects: ☐ None Anticipated

☐ YES. Please describe:

Actions to be taken in case of reaction to medication and instructions to paramedics:

Storage and taking of medication: The general school policy is that all medication is to be stored and taken by the student in the school office unless specifically directed by the child's physician. School personnel who assist the child are not likely to have had medical training.

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other:

Administration of medication: ☐ Medication may be carried by the student.
☐ Medication kept in the school office/classroom.

Please indicate if you have attached additional information: ☐ Yes ☐ No

Name, address, and phone of physician

Date	Signature of Physician

Approved: 000830

PARENT OR GUARDIAN'S REQUEST FOR ASSISTANCE WITH PHYSICIAN PRESCRIBED MEDICINE, WAIVER OF CLAIMS, AND RELEASE OF LIABILITY

PLEASE PRINT

Name of Student (First, MI, Last Name)	Name(s) of Parent(s) or Guardian(s) (First, MI, Last Name)	
Telephone Numbers where parents/guardians can be reached during the school day. Include also cellular and pager numbers.		
Name of School	Grade	School Year 2013-2014

I, the undersigned, hereby request the school, named above, to assist in the matters set forth on the physician's statement on the reverse side of this form. I will notify the school immediately if there is a change in my child's medication schedule or if the physician prescribing the medication is no longer providing health care for my child. I understand it is my responsibility to send the medication to the school office in a pharmacy container labeled with my child's name and the doctor's instructions. I understand that in case of an error or adverse reaction to medication, the school resources are limited to calling emergency services (911) and calling the child's parent/guardian.

The general school policy is that all medication is to be stored and administered in the school office unless specifically directed by the child's physician. The school prefers that medication be scheduled outside of school hours whenever possible. The general school policy is that all medication is to be stored and taken by the child in the School office unless specifically directed by the physician. The school shall not be responsible for the cost of medication in the event of loss of refrigeration from power outages or other causes.

Check one below:

☐ I request designated school personnel to assist my child when my child takes medication. I understand and accept the fact that school personnel who assist my child are not likely to have had medical training.

☐ If medically necessary, as directed by the child's physician, I give permission for my child to carry and self-administer the above referenced medication. I have trained my child on how to self-administer this medication. The school may void this request if my child does not follow the dosage or directions of his/her physician.

I understand that the school reserves the right to discontinue assistance to my child in the child's taking of prescribed medication at school. I understand that the school is not obligated to store or assist my child when my child takes medication. Therefore, in consideration of this assistance, I, release and discharge the school from any and all claims for liability or responsibility for death, illness, adverse reactions, personal injury, or property damage that my child or I may suffer as a result of this arrangement, whether or not such injuries or damage are caused by negligence (either active or passive) of the school. This waiver of all claims and release of the School also releases the Diocese of Fresno Education Corporation, The Roman Catholic Bishop of Fresno (a corporate sole), the Diocese of Fresno, all other Diocese of Fresno schools, all parishes, all affiliated organizations, and all of their officers, clergy, agents, and employees.

Date	Signature of Parent or Guardian
Date Received at School	Signature of School Representative that received this request
Date Request Approved	Approved By

Both sides of this form must be completed and returned to the school before any prescribed medication may be taken at school. This form may only be used for one medication. Use additional forms for other medications. This request will be effective for one school year only. This form will be kept in your child's medical file.

Approved: 000830