VILLA MARIA ACADEMY

AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

Student's Name:____Grade________

Date of Birth:__________________Allergies:____

~~~~~~

Administration of prescription medication in school requires a written order form from a physician and a parent signature. Please have the medication form below completed and return it to the health office. Written permission from your physician can be faxed directly to the school office. If you have any questions about this policy, please contact the school nurse.

PHYSICIAN'S REQUEST

Name of prescribed medication(s):____

Dose:____

Time to Administer:____

Treatment of:____

Route:____

Side Effects:____

Other medication student is taking____

Physician's Signature:________________________________Date:______________

Printed name of Physician:__________________**Phone Number:**_______________

I , the parent/guardian of ____request that the Villa Maria Academy nurse, Principal, or designee administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against Villa Maria Academy, its Board of Directors and all of its' employees unless they are negligent with regard to any claim for injury in connection with dispensation of the prescribed medication.

I also agree to provide the medication to the school nurse in the original pharmacy container or place it in a sealed envelope for transport to school. I accept responsibility to provide a physician's note and written instruction if the medication is changed or discontinued. I also give my permission for the school to communicate with the physician regarding this medication/medical condition.

Parent Signature:____**Date:**__________________
~~~~~~