ARCHDIOCESE OF MIAMI

All Saints Catholic School

PRESCRIPTION MEDICATION RELEASE FORM

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

In order for All Saints Catholic School personnel to dispense medication to your child, this completed form, along with the medication is to be brought to the school by the parent or student. Prescribed medication/treatment may be administered by designated school personnel. The medication should be brought to the school in the original container appropriately labeled by the pharmacy.

NOTE: Prescribed asthma inhaler may be kept by the student and self-administered if a physician indicates the need in writing and considers the student sufficiently responsible. In addition, the physician should list any precautions to be followed on this form.

Student Name:		**ID:**	
		Grade:	

Allergies:

Name of Medication:	
Reason for Medication:	
Dosage:	
Form of Medication/Treatment:	☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other:
Time Medication is given:	
Restrictions and/or Important Side Effects:	☐ None anticipated ☐ Yes, please describe:
Special Storage Requirements:	☐ None ☐ Refrigerate ☐ Locked storage
Special Administration Procedures:	☐ None ☐ Crush pill ☐ With Food
Start Medication Date:	
Stop Medication Date:	

I, the undersigned, the parent/guardian of ______________________________, request that the above medication or procedure be administered to my child. I release the school personnel and the school district from liability stemming from adverse reactions and all other adverse effects which may occur because of administering the aforementioned medication.

Parent/Guardian signature:		***Date:***	

Medication Treatment Plan

All Saints Catholic School

954-742-4842 Phone **954-742-4871 Fax**

Date: __________

Name of Student: ____________________________ DOB: __________________ Grade:_______

MEDICATION TREATMENT PLAN TO BE COMPLETED BY PHYSICIAN

Diagnosis:

____

____

Medication, Dosage, Specific Times & Directions for Administration (Please write each medication dosage, frequency, and time separately):

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NOTE: Medication MUST be supplied in the original prescription container with the Pharmacy Label intact.

Side Effects/Special Instructions:

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____

Treatment Plan/Duration:

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Special Procedures: (List any Special Procedures in which the student has been trained, i.e.: Insulin Administration, Glucose Testing, EPI-Pen Use, Nebulizer, etc.)

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Physician Name or Group Practice Name: ______________________________________

Physician Office Number: ____

Physician Fax Number: ____

Physician Signature: ____