PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

______________________ is under my care and should receive ______________
Name of Pupil Name of Drug

______________________________ at the following times: ______________
Dosage, Route

Specific instructions for administration: ______________________________

Possible side effect to watch for: ______________________________

Expiration date of this request: ______________________________

____
Date Physician's Signature Physician's Phone Number

____

PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give permission to the principal or his/her designee (e.g., school nurse or responsible person) to administer the following medication to my child.

Name of Pupil: ______________________________

Name of Drug: ______________ Dosage: ____________ Route: ______

At the following times: ______________________________

Please regard my signature below as my assurance that I release the Diocese of Cleveland, All Saints of St. John Vianney School, PSI, and any or all the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

______________________________ ______________
Signature of Parent/Guardian Date