St. Louis Catholic School

17 St. Louis Place
Batesville, IN 47006
(812) 934-3310

PHYSICIAN'S PERMISSION FOR PRESCRIBED MEDICATION

Student_____ Date of Birth:___/___/_____
Last First M

TO BE COMPLETED BY PHYSICAN OR AUTHORIZED PRESCRIBER

Name of Medication: _____

Reason for Medication: _____

Form of Medication: ____tablet/capsule ____liquid ____injection/epi-pen ____nebulizer

*Parent and physician understand school personnel cannot administer prescription drugs in amounts, which exceed the recommended dosage in the Physician's Desk Reference (PDR).

*Instructions: Time to be given at school (E.S.T.)_____

Dosage:_____

Start:_____Date form received or other date (specify):_____

Stop:_____End of School year or other date/duration:_____

Restrictions and/or important side effects:_____

Storage Requirements:_____

Is this student both capable and responsible for self-administering this inhaler/epi-pen/insulin at school?

_____No _____Yes, with Supervision _____Yes, without Supervision

While transporting on school bus? (unsupervised only) _____NO _____YES

Physician's Signature_____Date:_____

Parent or Guardian gives permission to school personnel to administer the above medication as instructed and agrees to:

1. Deliver the medication to the school in the original container as dispensed by the pharmacist or physician
2. Notify the school if a change of physician or if the medication is changed or discontinued.

Parent/Guardian understands it is the student's responsibility to report on time for this medication. Parent/Guardian agrees to hold employees and school commission free from all responsibility for results of such medication.

Parent/Guardian Signature_____ Date:_____