

**St. Joseph/Marquette Catholic School**  
**PHYSICIAN'S/DENTIST'S ORDERS FOR MEDICATION AT SCHOOL**

Whenever possible, the parent and physician will design a schedule for giving medication outside of school hours. Medication is ordered to be given to a student at school only when necessary. Medication is defined as both prescription and non-prescription. Medication may be kept by patient and self-administered upon physician authorization only (this is usually inhalers only) or medication may be kept and administered by a school nurse, principal, or other designated personnel.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

**BOTH PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS MUST FOLLOW THIS POLICY AS MANDATED BY STATE LAW**

Student name: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Diagnosis for which the medication is given: \_\_\_\_\_

Form or dose of medication: \_\_\_\_\_

If medication is to be given DAILY, at what time: \_\_\_\_\_

Physician orders that the student \_\_\_\_\_ may \_\_\_\_\_ may not keep medications on person and self-administer. (This is primarily for inhalers.)

Side effects of the drug (if any) to be expected: \_\_\_\_\_  
\_\_\_\_\_

Length of time this authorization is valid: \_\_\_\_\_

The student is allowed by physician's order to have the above named medication on person and self-administered as prescribed: \_\_\_\_\_

Physician's signature is required

Physician or Dentist signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office address: \_\_\_\_\_ Office phone: \_\_\_\_\_

**PARENT PERMISSION STATEMENT:**

I request that my child be allowed to take the prescribed medication as described above. The medication is to be furnished by the parent in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only. In case of necessity the school may discontinue administration of the medication with proper notice. I am the parent or legal guardian of the child named on this form.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Student address: \_\_\_\_\_ Emergency phone: \_\_\_\_\_

Medication kept at school verified by school nurse: \_\_\_\_\_ / \_\_\_\_\_  
School Nurse Signature Date