

**ST. JANE FRANCES de CHANTAL SCHOOL
REQUEST FOR ADMINISTRATON OF MEDICATION**

Schools in Pennsylvania may administer medication to a child only under orders of a physician. This applies to both **prescription** and **over-the-counter** drugs. Please complete this form if you wish your patient to receive medication during school hours.

STUDENT'S NAME _____ BIRTHDATE _____ GRADE _____

MEDICATION PRESCRIBED _____

PRESCRIBED DOSAGE AND FREQUENCY _____

TIME OF DAY _____

REASON FOR MEDICATION _____

SIDE-EFFECTS _____

The authorization shall be in effect until (max. one school year) _____. I certify that I am the physician who prescribed the above medication and that the student who is to receive the medication is under my care. I further certify that it is imperative that the medication prescribed be taken during school hours.

DATE _____ SIGNATURE OF PHYSICIAN _____

PRINT NAME OF PHYSICIAN _____

ADDRESS OF PHYSICIAN _____

PHONE NUMBER OF PHYSICIAN _____

This will confirm the fact that we have requested the School, and in particular the school nurse or other designated school employee, to administer the medication at such time or times as directed in writing by the physician. Medication will be provided to the school by the parent or other responsible adult. For emergency medications that require self-carry the self-carry form will also be completed. We will furnish you with a supply of medication in its' original container and agree, as an inducement to you to comply with our request, to relieve the local school (Wilson Area School District) employee's, the Diocese of Allentown, and St. Jane Frances de Chantal employees or other designated employee from liability for injury due to use, misuse, or abuse of the said medication or from any kind of injury which may arise from the administration of said medication by injection on our child, whether such damage, injury, use, misuse, or abuse be caused by or result from the negligence of the School, its servants, agents, or any other person or persons whatsoever.

SIGNATURE OF PARENT/GUARDIAN _____

PRINT NAME OF PARENT/GUARDIAN _____

DATE _____