ROANOKE CATHOLIC SCHOOL

Physician Authorization for Prescription Medication in School
This form may be returned by FAX: 345-0785, attention School Nurse

Student's Name: ______________________________ Grade: _________________

Allergies: ________________________________ Birthdate: __________________

PRESCRIPTION MEDICATION AUTHORIZATION

(By Healthcare Professional Only)

Relevant Diagnosis: ____________________________________

Medication: ____

Dates medication must be administered at school: ____ Short Term (List dates) ____________________

___Every day at school ____ Episodic/Emergency Events ONLY

Dosage: _______________ Route: __________ Time(s) of School Day: __________________

Adverse side effects from this medication may occur: ____ YES ____ NO

If yes, describe____

Action/ Treatment for reactions:____

FOR ASTHMATIC or DIABETIC STUDENTS ONLY:

This student is both capable and responsible for self-administering this medication:
___ NO ___ YES – Supervised ___ YES- Unsupervised

Student may carry this medication: ____ NO ____ YES

Printed Name: _______________________
Telephone Number: ___________________

Physician Signature: ____________________________ Date: __________________
(required to self carry)

PARENTAL CONSENT

I am the parent or guardian of ____________________. I give my permission for him/her to take the above prescribed medication while in Roanoke Catholic School. I hereby acknowledge that I have read and understood the medication guidelines stated in the School Handbook. I hereby release Roanoke Catholic School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize the school nurse to contact the licensed prescriber to discuss any concerns regarding this medication.

_____________________________ _____________________________ _______________

Parent /Guardian Signature Daytime Phone(s) Date