

**DIOCESAN CATHOLIC SCHOOLS
PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION
DURING SCHOOL HOURS**

Dear Doctor:

The parent/guardian of _____, has requested that we administer medication(s), namely _____ to the student during the school day.

It is our procedure to request that medication be given before or after school hours whenever possible.

If it is essential that the student receive the medication(s) during school hours, please complete the following information:

Name of Medication(s) _____

Dosage _____

How to Be Administered (Oral or Injection) _____

Time Schedule for Administration _____

Duration of Medication Administered _____

Possible Side Effects or Contraindications _____

Curtailmnt of Specific School Activity _____
(Sports, Lab, Drivers' Training, etc.)

Other Medications Prescribed by Physician That Student Is Taking Outside of School Hours _____

Is Student Capable of Self Administration Yes _____ No _____

Date

Physician's Signature

Physician's Telephone No.

Thank you for your cooperation.

School Nurse

DIOCESAN CATHOLIC SCHOOLS
DIVISION OF PUPIL PERSONNEL SERVICES
DEPARTMENT OF SCHOOL HEALTH SERVICES

CONSENT FORM FOR PRESCRIPTION MEDICATION

TO: _____
Building Principal

We request that school personnel administer this prescribed medication to _____ according to the attached directions from our attending physician.
Student's Name

As parent/guardian of _____, we hereby
Student's Name

release the Diocesan Catholic Schools and all its employees from any and all liability for damages our child may suffer as a result of this request.

Any change in type of dosage of medication must be reported to the school immediately.

Date

Signature of Parent/Guardian

*St. Mary's Assumption School
41 Carroll Street
Pittston, PA 18640
(570) 654-8313
www.sma-pittston.org*

CONSENT FORM FOR NON-PRESCRIPTION MEDICATION

TO: _____
Building Principal

We request that school personnel administer this medication
_____ according to the directions written below to

Name of medication

Student's Name

As parent/guardian of _____, we
Student's Name

Hereby release St. Mary's Assumption School and all its employees from any and all liability for damages our child may suffer as result of this request.

Any change in type or dosage of medication must be reported to the school immediately.

Directions for administering medication:

Date

Signature of Parent/Guardian