Please return to

1300 Urban Drive · Columbus, Ohio 43229
p. 614-888-4268 · f. 614-888-4435

REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

I. PHYSICIAN'S SECTION

_____**is under my care and should receive**

_____**at the following times**_____
(Name of Drug, Dosage, Route)

Specific instruction for administration:_____

Possible side effects to watch for:_____

Special storage instructions:_____

Starting date for medication:_____

Expiration date of this request:_____

_____	_____	_____
Physician's Signature	**Physician's Phone Number**	**Date**

II. PARENT'S SECTION

I hereby request and give my permission to the administration by approved personnel to administer the above stated medication to my child. I also understand that the medication will be brought to school in the container in which it was dispensed. I further acknowledge by signing this form that the school or its personnel are under no obligation to render assistance in administering medication and do hereby release all designated employees from liability for damages or injury resulting from either performing or not performing the assistance required.

I have read and understand the policy for administration of medication.

Name of Child:_____

Home Address:_____

School:_____St. Anthony School_____ **Grade :**_____

Date:_____ **Signature of Parent:**_____

Dept. of Education
Catholic Diocese of Columbus
5141.0

Adopted: 5/85
Revised: 5/87
Reviewed: 2/90