

Cardinal Newman High School
(561) 683-6266, FAX (561) 683-7307
FOR USE IN TIMES OF ILLNESS AND REGULARLY SCHEDULED MEDICATIONS FOR YOUR CHILD
AUTHORIZATION FOR STUDENT MEDICATION

Name of Student/Grade: _____ Birthdate: _____

Diagnosis: _____ Any Known Allergy (Food or Drug) _____

Name of Medication: _____ Date to be Discontinued: _____

Dosage: _____ Specific Time: _____ Frequency: _____

(Amount to be Given):

Form of Medication (Circle):

1. Oral 2. Injectable 3. Inhaler 4. Other (Specify) _____

Location of medication: _____ Stored in Health Room _____ Carried on Person (Epi-Pen, Inhaler) _____ Other (Specify) _____

Desired action of medication: _____

Symptoms of adverse reaction to medication: _____

Does the student take above medication or any other medication at home? Yes _____ No _____

If yes: Medication _____ Dose _____ Frequency _____

Physician Authorization (Needed for prescribed medication and over the counter medications)

- The student has been trained and has my permission to self administer the prescribed medication (epi-pen, insulin, asthma inhalers and nebulizers only) if the school nurse determines it is safe and appropriate. YES _____ NO _____
- The parent knows of this request and has agreed to provide the supplies needed for the above medication.
- Should the student manifest any of the above symptoms which may be caused by the medication, I understand that the parent will be contacted and the School Health Directives relating to emergency care will be followed.

Physician's Name (Print) _____ Physician's Signature _____ Date _____

License # _____ Telephone # _____

Parent Permission

I Understand That:

- Medication orders are valid for one school year only and need to be renewed at the beginning of each school year.
- Medication(s) must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication(s) as needed.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I understand I may retrieve the medication from the school at anytime; however, the medication will be destroyed if it is not picked up within one week following termination of the order or two days beyond the close of the school year.

I hereby give my permission for my child (named above) to receive medication during school hours supervised by the nurse or administration designee. I understand that Cardinal Newman undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release Cardinal Newman High School and its agents, volunteers and employees from any and all liability that may result from my child taking the medication.

Parent/Guardian Signature _____ Date _____ Home/Emergency Phone # (Work, Cell, Beeper) _____

Signed before me this _____ day of _____ in the year of _____.

The State of _____ The County of _____.

SEAL _____

(Notary's Signature)

(My Commission Expires)