PHYSICIAN'S STATEMENT REGARDING ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

PLEASE SCHEDULE MEDICATION OUTSIDE OF THE SCHOOL HOURS WHENEVER POSSIBLE

1. Name of pupil ______________________________ Date of Birth ___/___/___
2. Address ______________________________ Telephone __________
3. Condition for which medication is to be given ______________________________
4. Name of medication ______________________________
5. Method of administration: Oral _____ Inhalator _____ Injection _____ Other _____
6. Dose ____________________ Schedule of doses ____________________
7. The medication is to be continued as above until ____________________
8. Precautions advised ______________________________

   Possible reactions to medication ______________________________

   Actions to be taken in case of reaction to medication ____________________

   ____
9. Check one below:

   _____ I give this pupil permission to self administer the above medication.

   _____ I authorize designated school personnel to administer the above medication.
10. Print name and address of physician Date ____________________

    ______________________________ Phone ____________________

    ____

    ______________________________ ______________________________

    Signature of Physician

PARENT'S OR GUARDIAN'S REQUEST FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL AND WAIVER AND RELEASE FROM LIABILITY

The undersigned hereby requests ______________________________ School to assist ______________________________ in the matters set forth in the above Physicians statement.

11. Name of parent or guardian ______________________________

12. Telephone where a parent/guardian can be reached during the school day ________

13. Language(s) used at home ______________________________

I will notify the Principal of the school immediately if there is a change in my child's medication schedule or if the physician prescribing the medication is no longer providing health care for my child.

I understand it is my responsibility to send the medication to school in the original pharmacy container including the child's name and the doctor's instructions.

Check one below:

_____ **I give** ______________________________ **permission to self-administer** the above referenced medication.

_____ I authorize designated school personnel to administer this medication.

I understand that ______________________________ School reserves the right to discontinue its involvement in the above referenced administration of medicine.

I UNDERSTAND THAT ______________________________ IS NOT LEGALLY OBLIGATED TO STORE OR ADMINISTER MEDICATION FOR STUDENTS. THEREFORE, IN CONSIDERATION FOR THE ABOVE REFERENCED ARRANGEMENT, THE UNDERSIGNED DOES HEREBY RELEASE AND DISCHARGE THE ARCHDIOCESE OF SAN FRANCISCO, ITS CONSTITUENT ORGANIZATIONS, INCLUDING, BUT NOT LIMITED TO ______________________________ PARISH/SCHOOL AND THEIR OFFICERS, AGENTS AND EMPLOYEES, FROM ANY AND ALL CLAIMS FOR PERSONAL INJURIES OR PROPERTY DAMAGE THAT I OR MY CHILD MY SUFFER AS A RESULT OF THIS ARRANGEMENT WHETHER OR NOT SUCH INJURIES OR DAMAGE ARE CAUSED BY THE NEGLIGENCE (WHETHER ACTIVE OR PASSIVE) OF ANY OF THE ENTITIES OR INDIVIDUALS NAMED OR DESCRIBED ABOVE.

____
Signature of Parent or Guardian

ONE MEDICATION PER FORM, PLEASE

Return completed form to the Principal.