ARCHDIOCESE OF NEW ORLEANS

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

Whenever prescription medicine needs to be given by school personnel, this form must be completed and accompany the medication. A new form must be filled out and signed by your doctor if at any time your child's medication or dosage changes.

Please complete all information on this form and return it to the school office.

1. **Child's name ______________________________ Grade __________**
2. **Medication to be administered _______________________________________**
3. **Dosage ____**
4. **Purpose of medication ____**
5. **Time of day medication is to be given __________________________________**
6. **Anticipated number of days medication needs to be given during school hours____**
7. **Possible side effects ____**

My signature authorizes the school secretary, principal, or designee to administer the medication, as stated on this form, to my child, __________________, and that any side effects from the medication are not the school's responsibility.

Parent's Signature ____________________________ Date ________

Doctor's Signature ____________________________ Date ________