

Most Holy Redeemer Inter-Parochial School

302 E. LINEBAUGH AVENUE
TAMPA, FLORIDA 33612
(813) 933-4750

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

20__ - 20__ School Year

Date: _____

Child's Name: _____ D.O.B. _____ GRADE _____
Last First M.I.

I HEREBY AUTHORIZE, REQUEST AND GIVE MY CONSENT TO THE PRINCIPAL, OR HIS/HER DELEGATE (SCHOOL NURSE OR OTHER RESPONSIBLE PERSON) TO STORE, SUPERVISE AND/OR ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD. IT IS IMPOSSIBLE TO ARRANGE FOR THIS MEDICATION TO BE TAKEN AT HOME, THEREFORE IT MUST BE ADMINISTERED DURING THE SCHOOL HOURS.

ALL MEDICATION MUST BE PROVIDED BY THE PARENTS/GUARDIANS AND WILL BE KEPT IN THE SCHOOL OFFICE. Only in extreme cases, where the physician deems it medically necessary, will it be permissible for a child to keep their medication on them or in their bookbag, i.e. asthma inhaler. The child's physician must state the need for the child to have immediate access to the medication on her/his prescription form and sign/date the statement. The statement will be attached to this Authorization Form.

CHECK ONE: Prescription Medication Over-the-counter Medication (includes cough drops)

Name of Medication: _____

Time(s) to be administered: _____

Dosage to be administered: _____

Date to start: _____ Date to end: _____

Health condition requiring this medication: _____

Possible side effects/Special Instructions: _____

Prescribing Physician's Name: _____ Phone _____

I RELEASE THE DIOCESE OF ST. PETERSBURG AND MOST HOLY REDEEMER INTER-PAROCHIAL SCHOOL AND ANY AND ALL EMPLOYEES AND STAFF, FROM ANY LIABILITY OR DAMAGES RESULTING FROM THE CONSEQUENCES OF ALLOWING SCHOOL PERSONNEL TO ADMINISTER THE ABOVE MEDICATION, OR ANY ADVERSE REACTIONS OF MY CHILD TAKING OR FAILING TO TAKE THIS MEDICATION AT THE TIME PRESCRIBED. I UNDERSTAND THAT I HAVE THE PRIMARY RESPONSIBILITY FOR ADMINISTRATION OF MEDICATION, BUT IN MY ABSENCE, I CONSENT AND AUTHORIZE THE SCHOOL TO ASSIST ME WITH THIS OBLIGATION. I FURTHER AGREE TO KEEP THE SCHOOL INFORMED IN WRITING OF ANY REVISIONS TO THE PHYSICIAN'S PRESCRIPTION AND DIRECTION. I ALSO UNDERSTAND THAT THE SCHOOL IS NOT RESPONSIBLE FOR THE LOSS OR THEFT OF MY CHILD'S MEDICATION.

Parent/Guardian Signature

Home phone

Work Phone