



SAINT MARTIN
DE PORRES *High School*

**PHYSICIAN/AUTHORIZED PRESCRIBER
REQUEST TO ADMINISTER
MEDICATION AT SCHOOL**

Student Name: _____ **Birthdate:** _____ **Grade:** _____

Address: _____ **Telephone:** _____

Medical Diagnosis/ Reason for Medication at School: _____

Name of medication to be taken at school: _____

Form (Tablet, Liquid, etc.)	Dose	Route	Frequency (Daily, PRN, etc.)	Time(s) at school

Restrictions/ side affects or special instructions: _____

Start date: _____ **End date:** End of school year or _____

Medications/doses at home: _____
(List all that apply)

Physician/Authorized Prescriber Signature

Date

Printed Name

Telephone

**PARENTS REQUEST AND RELEASE FOR ADMINISTRATION OF
MEDICATION AT SCHOOL**

I give permission for my child, _____, to receive the above medication at school according to the prescriber's order and school policy. It is understood that St. Martin de Porres High School and all of its personnel are absolved from any liability which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. I give permission to the School Nurse to communicate with the prescriber regarding my child's treatment plan.

Parent/Guardian Signature

Date

Telephone (work /cell/ emergency)

Reviewed by Nurse (name): _____ date: _____