SAINT THOMAS AQUINAS ACADEMY
REQUEST FOR GIVING MEDICATION AT SCHOOL

Request for Giving Medication form is acceptable for all forms of medication with the exception of inhalers. Please see the Asthma form for consent for inhaler use at school. This form is available in your student's school office.

______________________________ **SCHOOL** **YEAR:** ______________________________

I request:

______________________________ ______________________________
(Student Name) (Date of Birth)
Receives the medication prescribed by:

______________________________ ______________________________
(Physician's Name) (Phone Number)

____
(Physician's Address)

Note: All medication, both prescription and over the counter (if different from stock), **is to be furnished by the parent and is to be in an original container.** For a prescription medication, ask the pharmacy to divide the medication into two completely separate labeled containers, providing one for home and one for school.

Please fill in all information below.

Name of medicine: ______________________________

Reason for medication: ______________________________

Amount to be given: ______________________________

Route: (circle) By Mouth Injection Other: __________

Time of day to be given: ______________________________

For the period from: Date: ____________________ to Date: ______________

Possible side effects: ______________________________

Direct contact shall be made with the physician should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state): ______________________________

I give permission to designated school staff to give the above selected medication to my child during the school day. I also agree to give my permission to the school nurse and/or school health staff to contact the child's physician if needed.

I give permission to designated school health staff to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse affects of the medication.

I further agree to hold Saint Thomas Aquinas Academy and the Saint Thomas Aquinas Academy employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

I agree to notify the school at the termination of this request or when any changes in the above order(s) is necessary.

______________________________ ______________________________
Date Signature of Parent/Guardian

______________________________ ______________________________
Date Signature of School Nurse

______________________________ ______________________________
Date Signature of Physician – **must have for prescription medication**