Sacred Heart School and Saint Francis Xavier School Partnership
Medication Administration Plan/Parent Guardian Permission

Name of student ____________________ Date of Birth__________School____________________ Grade________

Parent/guardian name____

Home telephone________________________________ Business telephone____________________________Cell Phone_____________________________

Emergency Contact______________________________ Relationship__________________Phone________________________Cell Phone______________

Food/drug/other Allergies:

Diagnoses:

Name of Medication to be given during school hours:

Name of licensed prescriber: **Phone:**

Date Ordered: **Duration of Order:** **Dosage:** **Frequency:**

Route of Administration: **Expiration Date of Medications:**

Specific Directions, e.g. times to be given:

Possible Side Effects, Adverse Reactions:

Other medications taken by student at home and/or school:

I give permission for the school nurse (or appropriately trained school personnel, for the use of epinephrine, in an emergency) to give

________________________ (medication name) prescribed by__________________________(licensed prescriber) to my child. YES □ NO □

I give permission for my son/daughter to self-administer medication if the physician and school nurse determine it is safe and appropriate. YES □ NO □

I give permission for the school nurse to share information relevant to this medication as she/he determines necessary for my child's health and safety. YES □ NO □

Plan for Field Trips: I give permission for the responsible adult designated by the school nurse to administer, Medication Name: ____Dosage:____________________________Time:______________________

Prescribed by____ to my child__________________________________ if attending a field trip.

_______ YES □ NO □

Plans for teaching self-administration, if applicable:

Location where medication administration will occur: _____Health Office _____Other (specify)____________________________________

Plan for monitoring medication, if needed:

I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up by the last day of the school year or within one week following the termination of the medication order.

School Nurse Signature_______________________________________ Parent/Guardian Signature___________________________________

Date______________________ Date ____________________

Student's Signature, if appropriate__________________________

Date ____________________