Appendix 2

Parental consent for prescription and over-the-counter medication administration in school

If your child will require prescription or over-the-counter medication while at school, this form and a Health Care Provider Authorization form are required.

Today's date	
Student name	
Date of birth	
Grade	
School year	
School name	

Name of medication	
Medication is for	
Treatment lasts until	
How to administer	
Medication allergies	
Instructions	

For prescription medications – Prescription medications must come to school in the original container with the label stating the pharmacy name and phone number. The label must also include the child's name, name of the medication, time the medication is to be given, dosage, route the medication is to be given, date of expiration, and the licensed healthcare provider's name and phone number. Please ask the pharmacist for a separate medicine container to keep at school.

For over-the-counter medications -- Over-the-counter medications must be labeled with the child's name. Dosage must match the signed Health Care Provider Authorization form, and medicine must be packaged in the original container. Herbal medications and nutritional supplements are considered in the same category as OTC medications.

By signing this document, I give permission for this medication to be administered to my child at school. The school has my permission to call the prescribing healthcare provider with any questions regarding the medication.

I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents, or representatives, from liability that may arise from administering medication to my child.

Print parent/guardian name	
Date	
Signature	

Cell phone	
Home phone	
Work phone	

Please print this form double sided

Appendix 2

For office use only

Medication Administration Daily Log

Student name	
Grade	
School year	
School name	

Initials	Name

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										