

ST. PETER SCHOOL
702 Cleveland Ave NW
Canton, Ohio 44702

Prescription Medication Administered at School

School Year: _____
Grade: _____

Attach
Student
Picture if
Available

Student Name _____ Birthdate _____
Student Address _____

To Be Completed by Physician/Healthcare Provider:

Name of Medication _____ Dose _____
Time to be given _____ (during school hours)
Reason for Medication _____
Form of medication: _____ Tablet _____ Liquid _____ Inhaler _____ Nebulizer _____ Other _____
Start Date: _____ Stop Date: _____
Special Instructions: _____
Potential adverse reactions to be reported: _____

Physician/Healthcare Signature: _____ Date _____
Physician/Healthcare Provider Name (please print) _____
Phone: _____ Fax: _____

Parent/Guardian: I give permission for my child to receive this medication at school according to the school policy and as instructed by my healthcare provider.
I agree and am responsible to:

- Deliver my child's medicine to school in its original container and labeled by a pharmacist or healthcare provider.
- Tell the school as soon as possible if there is a change in the use of my child's medicine
- Tell the school if my child gets a new healthcare provider
- Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.

I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____ Emergency Alternate Phone: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

Clinic Use Only:	Date form received _____	Date Medication received: _____
Form Completed	Yes _____ No _____	Date form completed: _____
Notes:	_____ _____	