APPENDIX A

NEWMAN CATHOLIC SCHOOLS

Physician/Parent/Guardian Medication Administration Consent Form

All prescription medication dispensed at school, including students who carry and self-administer inhalers/Epi-Pens/insulin, must have written instructions signed by the Physician and the parent/guardian. Non-prescription medications require written instructions signed by the parent/guardian only. All medication must be in a container labeled from a pharmacy or manufacturer.

Name of Student: ______________________________ D.O.B. __________

School: ______________________________ Grade: __________

Diagnosis(es): ______________________________

Medication Name: ______________________________

Dosage Instructions: ______________________________

Specific instructions or reasons to contact Physician: ______________________________

____

Dates Effective: ____________________ to ____________________

Additional questions for Physician for inhalers, Epi-Pens and insulin:

Student is knowledgeable about his/her medication	Yes
Student has demonstrated correct use of his/her medication	Yes
Inhaler for asthma – may carry and self-administer	Yes
Epi-Pen for severe allergy – may carry and self-administer	Yes
Insulin for diabetes – may carry and self-administer	Yes

If students carry inhalers/Epi-Pens/insulin, it is recommended that back-up medication be stored in the health area.

Physician's signature directs the above medication administration and indicates his/her willingness to communicate with staff, designated by school principal or nurse, who administer the medication.

Physician's name, address and phone

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____
Physician's Signature (prescription meds only)
Date: ______________

Whenever there is any change in instructions for the above medication, a new form must be completed. This includes discontinuation of the medication. A new form must be completed for each school year.

I agree to hold the Newman Catholic Schools, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

I hereby grant permission to staff designated by school principal or nurse to supervise/administer the above medication to my child according to the instructions stated above and further authorize them to contact my child's physician if necessary. I understand that whenever possible, medication will be administered at home, before or after school hours.

______________________________ ______________
Parent/Guardian Signature Date

Student ______ Medication ______ Dosage ______ Time(s) Given ______ Year ______

Month	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
AUG																															
SEPT																															
OCT																															
NOV																															
DEC																															
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUNE																															

AB - ABSENT
R - REFUSED
N - NO SHOW
DC - DISCONTINUED
H - HALF DAY OF SCHOOL
M - NO MEDICATION IN SCHOOL

= A.M. Dosage
= P.M. Dosage

Signature ______