ARCHDIOCESE OF NEW ORLEANS

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

PLEASE COMPLETE ALL INFORMATION ON THIS FORM AND RETURN IT TO THE SCHOOL OFFICE

1. Child's Name: _____ Grade: _____
2. Medication to be administered:_____
3. Dosage: _____
4. Purpose of the medication: _____
5. Time of the day medication is to be administered: _____
6. Anticipated number of days child is to receive medication in school: _____
7. Possible side effects: _____

SIGNED PHYSICIAN STATEMENT MUST ACCOMPANY THIS REQUEST FORM

My signature authorizes the school principal, secretary, or designee to administer the above medication to my child _____, as stated on this form, and that any side effects from this medication are not the school's responsibility.

Parent's Signature: _____

Date: _____