Parent Request for School Personnel To Administer Medication to Student

St. Alphonsus School **Greendale, WI 53129**

Student's Name ___________________________________ **Grade** ___________

In effect for school year ______________ or until _________________
(list year 10-11, 11-12) (list end date)

Name of Medication ____

Reason for giving medication ____

Dosage and time schedule ____

Possible adverse signs or side effects of medication ___________________________________

Name of Pharmacy ____

Name of Physician ____

For inhalers: Student will ____ carry or _____ have in office (check one)

**For inhalers/epi pens: Student will _______ take on field trips ___ need it for sports

_______ need it for outdoor activities

**It will be the parent's responsibility to be sure the student has inhaler or epi pen available if needed for field trips and/or sports events and/or outdoor activities.

Note: The parent is to provide a properly labeled bottle. The label on prescription bottles shall contain the name and telephone number of the pharmacy, the student's name, the name of the physician, name of the drug, and the dosage to be given. Over-the-counter medication (Tylenol, etc.) must be in the original container and be clearly marked with the child's name, dosage, and directions.

Parent Signature _________________________________ **Date** ____________________

(for office use only)

Person in school to administer medication ________School Office Personnel________________

Signature of Principal ___________________________________ Date ______________