Appendix A

St. John the Baptist Catholic School
Jefferson, WI

Medication Administration Request Form

Student's Name _____ Home Phone _____

Home Address _____

School _____ Grade _____ Age _____

Note: For prescription medications, a licensed practitioner must complete Sections I and II, and parent or legal guardian must complete Section III. For non-perscription medications, the parent or legal guardian must complete Sections I & III.

SECTION I - Medication

Name of medication: _____ Dose: _____ Route: _____

Time to be given/taken at school: _____

Duration of treatment: From _____ Through _____

Purpose of medication: _____

_____

Side effects that should be reported to practitioner/parent: _____

_____

If medication is to be used as needed, specific symptoms that indicate its use are: _____

_____

SECTION II - Practitioner's Endorsement

Your signature below indicates your willingness to supervise the administration of the above medication by the school principal or his/her designee, and that you will accept direct communication from them as might be needed. Changes in this order must be in writing. Orders for medications used chronically must be renewed annually.

_____ _____

Practitioner's Name (Print or Type) Address/Phone Number

_____ _____

Practitioner's Signature Date

SECTION III - Parent's Permission

A. Mandatory for grades K-8 (except for self-administered inhalers for asthma or Epipens for allergic reactions - see Principal and Section B).

I give my permission to St. John the Baptist Catholic School to administer to my child, _____, the medication named on the reverse side by the instructions specified on the reverse side an, for prescription medication, further authorize them to communicate directly with the practitioner whose signature appears on the reverse side, should the need arise, for the safety of my child and other students.

_____ _____

Parent/Guardian Signature Date

****

B. Mandatory for any students 4-8 who will carry and self-administer an inhaler for asthma or an Epipen for allergic reactions.

I give my permission to St. John the Baptist School to allow my child, _____ _____ to self-administer the medication named on the reverse side by the instructions specified on the reverse side and, for prescription medication, further authorize them to communicate directly with the practitioner whose signature appears on the reverse side should the need arise, for the safety of my child and other students.

_____ _____

Parent/Guardian Signature Date

****

NOTE: Medications must be labeled with the student's name, the name of the medication, and the dosage. Prescription medications must also include the practitioner's name, and the pharmacy's name and phone number.

Students with asthma may self-administer inhalers for the condition if recommended by the prescribing practitioner and permitted by the parent/guardian with consent of the principal.