

Cleveland Central Catholic High School
Parental Request Form for Prescribed Medication (7/2010)

Student's Name _____ Homeroom _____ Grade _____ Date of Birth _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I give permission for my child, _____, to receive the medication below at school according to the Cleveland Central Catholic policy. It is understood that Cleveland Central Catholic and all its personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand the medication must be brought to school in the container in which the pharmacist dispensed it.

Date _____ Parental/Guardian Name (printed) _____

Signature: _____ Emergency phone number: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: _____

Name of medication: _____

Medicine Form: table/capsule liquid inhaler injection other _____

Special Storage Requirements: refrigerate none other _____

Start Date: _____ Stop Date: end of the year other/duration _____
 for episodic/emergency events only

Instructions (schedule and dosage to be given) _____

Restrictions/Side effects: _____

Adverse reactions that should be reported to the physician: _____

If prescribing an epipen or rescue inhaler, is the student capable and responsible for self-administering it?
 No Yes (supervised) Yes (unsupervised)

May the student carry the epipen or rescue inhaler? Yes No

Procedure to follow in event medication does not produce the expected relief: _____

Date: _____ Printed Name: _____ Signature: _____

Address: _____ Emergency phone: _____