Cleveland Central Catholic High School

Parent Request for the Administration of Non-Prescription Medication by School Personnel (8.17)

NON-PRESCRIPTION MEDICATION POLICY

To protect your child's safety school personnel will adhere to the following:

1. It is required that this form be completed which includes BOTH the parent AND physician signatures before any non-prescription medication is administered. This includes all over-the-counter products such as Tylenol, Advil, Dimetapp, etc.
2. The non-prescription medication must be in its original container and the bottle must be new with an unbroken seal. The bottle must have the student's name on it.
3. New request forms must be submitted each year.

Student: _____

Address: _____ City/State/Zip: _____

Name of Non-Prescription Medication and Dosage: _____

Times of Day to be Administered: _____

Number of Times/Intervals Medication is to be Administered: _____

Date to Begin Medication: _____ Date to End Medication: _____

Special Instructions for Administration of Medication: _____

This medication may be safely administered by non-medical personnel ☐ Yes ☐ No

This student is under my care. Non-prescription medication may be taken during school hours.

_____ _____
Physician's Printed Name Telephone

_____ _____
Physician's Signature Date

Please regard my signature below as my assurance that I release Cleveland Central Catholic High School and any or all of the school's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed.

_____ _____
Parent/Guardian's Printed Name Telephone

_____ _____
Parent Signature Date

Cleveland Central Catholic High School
Parental Request Form for Prescribed Medication (8/2017)

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 it's 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: _____