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

{Please return this document to the Guidance Office}

_____	_____	_____	_____
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: _____