<u>Prescription</u> Medication Administration

Saint Mary's Catholic School – Richmond

Student's Name: _____Grade: _____ Homeroom: _____

Name of Medication: _____

Diagnosis or Reason for treatment: _____

Duration of treatment:

____ Short-term for dates given –From _____to _____

____ School Year - _____

Date prescription filled: _____ *Expiration Date: _____

*Expires after the end of treatment: ____Yes ____*No - Please contact me to replace prior to expiration

Form: Capsule ☐ Tablet ☐ Powder ☐ Drops ☐ Liquid ☐ Spray ☐

Inhalant ☐ Skin prep. ☐ Auto - Injector ☐ Other_____

Dosage to be given:_____ Route:_____

Time of day to be given: ___ Any ___ Specific Time(s) _____

Frequency: ____ Daily ____ PRN (as needed) ____ Emergency/ Episodic Events ONLY

Special handling instructions: Refrigeration _____ Other: _____

Possible Reactions or Side-effects: _____

****Students with Anaphylactic Allergy / Asthmatic / Diabetic <u>ONLY</u>:**

This student is both capable and responsible for self-administering this medication:

☐ NO ☐ **YES - Supervised ☐** YES – Unsupervised

This student may self-carry this prescription medication: ☐ NO ☐ **YES

Prescribing Physician's Information:

Physician's Name: _____

Physician's Phone Number: _____

****Physician's Signature: _____**

****Required for self-carry or self-administer medications** - <u>NOT</u> required for others if prescription label is provided

Parental Consent

I, _____ (name of parent/guardian), give my permission for _____ (name of student), to take the prescribed medication listed above, as instructed, while at Saint Mary's School.

Parent/Guardian Signature _____

Date: _____ Emergency phone #: _____

(***All medication must be in the original container***