St. Benilde School

Request for School Personnel to Administer Medication

Please complete one form per child. All information on this form should be true and accurate. Please return this form to the school office.

Child's Name: ____ Age: ____________________

Medication to be Administered:____

Dosage:____

Purpose of Medication:____

Time of Day Medication is to be given:____

Anticipated Number of Days Medication needs to be given during school hours: ______________

Possible Side Effects:____

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Authorized school personnel will administer only medication prescribed by a licensed physician or dentist and dispensed by a registered pharmacist during school hours. A signed physician statement must accompany this request form. Medication must be sent to school weekly in its original container with the prescription label on it. Only one weeks dosage may be in the container. Medication must be dropped off by the parent (not the student) on Monday. If the container is empty on Friday, it will be sent home with the student. If not container has medication remaining, it must be picked up by the parent. Please enclose this form along with the medication in a gallon size ziplock bag with the child's name on the bag.

My signature authorizes the school administrative assistant, principal, or designee to administer the medication, as stated on this form, to my child, ________________________________, and that any side effects fro the medication are not the school's responsibility.

Parent's Signature____ **Date**______________