Saint Pius X School
PRESCRIPTION
Request Form

When it is essential that ***prescription medication*** be administered at school, and a parent cannot be at school to administer the medication, all items on this form must be completed before school personnel will dispense medication.

TO BE COMPLETED BY PARENT
I request the school nurse, building principal, or designee to administer the medication named on the reverse side and prescribed by the signing physician to my child, _______________________________at Saint Pius X School.

Further, I agree to:

1. Ask the physician if it is necessary to give the medication during the school day.
2. Deliver the medication to school in the ORIGINAL container in which it was dispensed, properly labeled to include the name of the student, physician, date, dosage instructions (quantity and time) and the name of the medication.
3. Notify the school in writing if my child changes physicians or if the medication, the dosage, or the procedure is changed or eliminated.
4. Hold the school or school personnel harmless for the administration of the medication described on the reverse side since school personnel are not legally obligated to administer medication to any child.

____________________________ Date__________________________
Signature of Parent or Guardian

____
Home Phone Cell Work

- If parents are separated and both still retain custody, ***both*** parents must sign. If children are in foster homes and placement is by the agency that holds custody, an agency representative must sign.

TO BE COMPLETED BY THE PHYSICIAN

I, the undersigned physician, am certifying that medication for the student listed below cannot be scheduled for other than school hours. Further, I realize that medically untrained personnel may supervise the administration of such medication. I am aware that medication must be sent to school in the ORIGINAL container in which it was dispensed and that no medication will be administered at school unless items 1 – 10 below are complete.

1. Student name____
2. Student address____
3. Name of medication____
4. Dosage to be administered__________________________Route_________
5. Times or intervals at which each dosage is to be administered____________

   ____
6. Date the administration of the medication is to begin___________________
7. Date the administration of the medication is to end____________________
8. Any severe adverse reactions which should be reported to the doctor______

   ____
9. Telephone number(s) where the doctor can be reached in an emergency

   ____
10. Any special instructions for administering the medication, such as storage requirements or sterile conditions__________________________________

______________________________	______________________________
Physician Name (Type or Print)	Physician Signature
______________________________	______________________________
Physician Address	Date