SAINT RAPHAEL SCHOOL
525 Dover Road
Bay Village, Ohio 44140
Telephone: (440) 871-6760
Fax: (440) 871-1358

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

The Following student is under my care and should receive the medication indicated below. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and therefore, must be taken during school hours.

Name of Student:_________________________________Date of birth or age:______

Address:____

City/State/Zip:____

Name of Medication, Dosage, and Route of Administration:______________________

____

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

Dates Administration to Begin and End:____________________________________

Adverse or Severe Reaction that Should be Reported to Physician:________________

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Special Instructions for Administration of Medication:___________________________

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This Medication Can Be Safely Administered by Non-Medical Personnel: ☐ Yes ☐ No

_______________________________________ ________________

(Physician's Signature) (Date)

_______________________________________ ________________

(Physician's Name) (Phone Number)

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I give permission for (name of child)________________________to receive the above medication at school. <u>MEDICATION MUST BE IN THE ORIGINAL CONTAINER</u>! In consideration of my child being administered the above specified medication at my request, on behalf of my child, my spouse, and myself. I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, Saint Raphael School, Saint Raphael Parish, employees and volunteers from all claims, judgments, liability for any injury or damage due to the designated administration of said medication to my son/ daughter.

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Parent Signature Date