ST. JOSEPH'S CATHOLIC SCHOOL

*"The Gift That Lasts a Lifetime"*

# Prescription Medication Administration Elementary

**Directions for Parent**: Please complete this form if your child requires prescription medication while attending school. (1) One of these forms **must** accompany **each medication** to be administered; (2) One of these forms **must** accompany each **new** medication or **change** in dosage that may occur during the school year; (3) All types of medications must be in their **original containers from the prescribing Doctor or Pharmacist**; and (4) As appropriate, this remains in effect through any summer school programs following the regular school year. Per School guidelines, parents (rather than children) should deliver medication to designated school personnel. Thank you!

| **Child's Name** | **DOB** | **Grade** |
|---|---|---|
| **Parent/Guardian** | **Grade/Teacher** | |
| **Parent/Guardian Phone Numbers:** **Home:** | **Work:** | **Cell:** |
| **Physician/Phone:** | **Hospital/Phone:** | |

## Health Care Provider Section- Prescription Medication

Diagnosis _____ Allergies_____

Medication name/strength:_____Dose_____Administration time: _____

Route (Circle one): Oral Inhaled/Nasal Topical Eyes Ears Other:_____

Reason for medication: Continue Until _____

Instructions for use:_____

Major side effects:_____

Authorization; (check)

_____I certify that the above named student is capable of self-administration of the above prescribed medication.

_____I certify that the above named student may carry the above medication.

_____I certify that the above named student will require assistant form the school.

**I certify that the information contained on this form is accurate and complete to the best of my knowledge**.

Healthcare Provider's Printed Name _____

Health Care Provider Signature _____ Date _____

**STUDENT CONSENT**

I acknowledge and agree to comply with the School's drug and alcohol policy, which contains restrictions related to medication, including rules prohibiting me from giving medication to other students. Anytime I believe that I am having a reaction to my medication, I will report this information to my teacher or another school employee.

_____ _____ _____

Printed Name of Student Signature of Student Date

**PARENT CONSENT**

I authorize my child to self-administer the above listed medication while at school and relieve the St. Joseph's School and personnel of all responsibility. The student may carry one day's supply of medication. I certify medications I have authorized my child to carry do not, to my knowledge, interact, and I certify that my child is not known to be allergic to them. I certify that the information included on this form is accurate to the best of my knowledge. I understand and hereby release St. Joseph's School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

**CONFIDENTIALITY WAIVER**

NOTE: Completion of this section by a parent/guardian authorizes the disclosure and/or use of your child's individually identifiable health information consistent with law (including HIPAA/FERPA).

I _____ authorize _____ to provide health
Parent/Guardian Name Name of Agency and/or Healthcare Provider

Information from my student's _____ medical record to St. Joseph's Elementary School.
Student's Name

The disclosure of health information is required for the school to provide medication and/or oversee my child's self-administration of medication.

☐ Requested information shall be limited to the following: All minimum necessary health information; or
Disease/condition-specific information as described: _____

This authorization shall become effective immediately and shall remain in effect until _____, or for the remainder of the school year. Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the educational setting.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

***NOTE: A copy of this confidentiality waiver must be sent to the student's healthcare provider upon completion***.