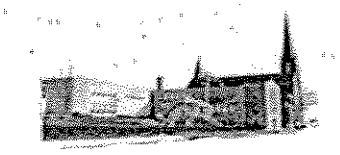

Holy Angels School
120 East Water St.
Sidney, Ohio 45365
www.holyangelscatholic.com

PARENTAL/PHYSICIAN PERMISSION TO ADMINISTER MEDICATION

This form must be completed by the prescribing physician and parent prior to administration of medication by school personnel. All medication must be in the container in which it is dispensed by the prescribing physician or licensed pharmacist.

STUDENTS NAME: _____ Grade _____

ADDRESS:

_____

SCHOOL:

_____

PHYSICIAN'S STATEMENT: _____ (Name) is under my care

and should receive _____ (Name of Drug and Dosage)

at the following time/times: _____

starting date _____ ending date _____

Special Instructions for administration:

_____

Possible side effects to watch for:

_____

PHYSICIAN: _____ _____ _____

(Signature) (Date) (Phone Number)

PARENT STATEMENT: I hereby request and give my permission to the school clinic aide or the principal's designee to administer the medication as stated above by the physician. I agree to submit a revised statement signed by the physician if any of the information originally provided by the physician changes.

_____

(Parent or Guardian Signature) (Date)

New request forms must be submitted each School Year

and whenever the Medication or Dosage is changed.