

SAINT JOHN SCHOOL  
REQUEST FOR ADMINISTRATION OF MEDICATION  
2011-2012

**NOTE TO PARENTS/GUARDIANS:**

**School personnel are not permitted to give medication of any kind – prescription and/or non-prescription, unless the parents/guardians request in writing that there is a need for such medication.**

I request that my child,

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Name (last, first) of Student	Birthdate	Date
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be given the following medication during school hours to promote optimum health, and to help maintain maximum school performance:

Name of Medication \_\_\_\_\_ Dosage strength \_\_\_\_\_

Reason for medication given \_\_\_\_\_

Form of medication to be given is circled below:

Tablet      Pill      Capsule      Liquid      Inhalation

Other (specify) \_\_\_\_\_

Dosage (amount to be given) \_\_\_\_\_

How often or at what time(s) \_\_\_\_\_

Date discontinued \_\_\_\_\_

I agree to hold the school harmless for the proper administration of medication provided by the parent/guardian, and for adverse drug reactions or side effects.

I agree to be responsible for maintaining an adequate supply of medication at the school to meet the child's needs. Medications must be properly labeled and stored in the office.

**Parent/Guardian Signature**

\_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

(Additional forms are available in the school office)