



**Diocese of Monterey**

**Physician Order and Parental Authorization to Administer Medication**

**In order for a student to receive medication at school or during school-related activities, the following criteria must be met:**

1. A new form must be completed **each** school year for **each** medication. A new form must also be completed whenever there is a change in the medication: name, form (tablet, capsule, liquid), dose (amount), or time given. If there are no changes, each form is good from August 1 of one year until July 31 of the following year.
2. A form is required for **any** medication: prescription, over the counter medicine or herbal supplement.
3. **For prescription medications both parent/guardian and physician must complete and sign this form.**
4. All medication must be in the original container or original package, and prescription medication must have the **current** prescription label.
5. The original form **must** be on file at the school. Medication and completed forms must be brought to the school by the parent.

**Parent Authorization**

**School Year:** \_\_\_\_\_

**Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
(Please Print)

**Parent/Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(Please Print)

**Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**School:** \_\_\_\_\_

**If Parent/Guardian is Unavailable, Emergency Contact:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

\*\*\*\*\*  
My child will need to take \_\_\_\_\_ at school. It is to be given at \_\_\_\_\_  
(Print Medication Name) (Time/s)

With the following special instructions: \_\_\_\_\_

*I, the undersigned, who is the parent/guardian of the above named student, requests that medication be administered to said child by a designated member of the school staff, in accordance with instructions outlined on the reverse side and authorized by our physician. I understand that there is no nurse on duty and non-medical staff will administer the medication. I understand that I have the right to come to the School and administer the medication myself.*

*I give my permission for the principal or designee, to communicate with my child's physician regarding the physicians' written statement for medication administration.*

*I understand the major responsibility for a child taking medication rests with the child and me as his/her parent/guardian, and that I am required personally to bring the medication to the School.*

*I also agree that the School and the Diocese of Monterey Education and Welfare Corporation and its employees shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of the School or the Diocese of Monterey Education and Welfare Corporation related to the administration of medication or by the student's self-administration of medication.*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Physician Order for Prescription Medication (Print):**

1. Name of Medication: \_\_\_\_\_
2. Reason for Medication: \_\_\_\_\_
3. Dosage: \_\_\_\_\_
4. Time/s: \_\_\_\_\_
5. Method:  Oral  Inhalation  Injection  Topical  Other/Explain \_\_\_\_\_
6. Possible Side Effects: \_\_\_\_\_
7. Special Storage Requirements: \_\_\_\_\_
8. Special Instructions/Precautions: \_\_\_\_\_
9. Will student need personally to carry this medication?  Yes  No
10. Will the student be "self" administering this medication:  Yes  No

The listed medication/s is necessary for:  A potentially life-threatening condition  
 Appropriate pupil interaction in school setting  
 To treat a current illness  
 Student comfort

Physician's Name (Print) \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

**PARENT REQUEST FOR MEDICATION SELF ADMINISTERED BY STUDENT AND REQUIRING SPECIAL STORAGE**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

I, the undersigned, who is the parent/guardian of the above named student, request and authorize the staff of \_\_\_\_\_ (School) to store my child's medication at the School site. As indicated in the physician's statement above, my child will self-administer his/her own medication when required, and I am not requesting School personnel to assist in the administration of my child's medication. However, I understand that all medication must be stored in the School office unless a physician orders that the student must personally carry the medication. I also understand that my child must self-administer the medications in the School office.

My child will need to self-administer his/her medication at School because he/she suffers from the following condition:

\_\_\_\_\_

My child will need to take his/her medication \_\_\_\_\_ (number of times per day) with the following special instructions.

\_\_\_\_\_

I request that my student's medication be stored in the following manner: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_