St. Thomas More Catholic School
Chapel Hill, North Carolina

Request for Prescription Medication to be Given during School Hours (to be completed by physician)

Student _____ Date of Birth _____

Medication _____ Dosage _____
(No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.)

Time(s) medication is to be given: _____a.m. _____ p.m.

To be given from (dates): _____to _____

Significant information (include side effects, toxic reactions, and omission reactions): _____
_____

Contraindications for administration: _____
_____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

____ Contact me at my office _____ Phone _____
____ Take child immediately to the emergency room at _____
____ Other option: _____

This medication will be furnished by parent/guardian within a container properly labeled by a pharmacist with identifying information (e.g. name of child, medication dispensed, dosage prescribed, and the time it is to be given).

Physician's signature _____ Date _____
DEA # _____

To be completed by parent

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employee from any and all liability that may result from by child taking the prescribed medication.

Signature of parent/guardian _____ Date _____
Telephone _____Cell _____

To be completed by school

Name of person to administer medication _____ Title _____

Approved by _____, Principal Date _____