



# Parental Request Allowing In-School Medication/Treatment

I request that Trinity Catholic School administer the medication that I have supplied.

**Prescription Medication:** I understand that prescription medication must be in the container in which it was purchased, with the name of the medication on the bottle, the dosage, times to be given, and the physician's name must be printed on the container. *I will obtain from the physician Standing Orders/Written Documentation for my child to receive this medication at school should it need to be administered for more than 15 days.*

**Over-the-Counter Medication:** I understand that over-the-counter medication (such as NSAIDs, antacids, cough medication, throat lozenges) must be provided by the parent. The medication must be in the original container with written instructions and permission from the parent. *If the medication is expected to be given for more than 15 consecutive days, written permission must be obtained from the physician.*

**Inhaler/Epi-Pens:** After proper documentation and demonstration of knowledge in use, I give my child permission to carry his/her inhaler/epi-pen on their person. The medication must have a proper prescription label as to identify the medication should it be lost/found. I realize it is my responsibility to notify the school nurse should there be any changes in protocol. *I realize it is my responsibility to notify the school nurse if I want my child to carry these types of medication.*

**Standing Orders from School Physician:** As outlined in the school handbook, the school nurse will follow the standing orders as recommended by the school physician, if need arises.

All medication that needs to be administered at school must be brought directly to the school nurse by a parent or legal guardian. All medication that is to be administered at school will be kept in the school nurse office and in a locked cabinet or refrigerator.

**NO MEDICATION WILL BE ADMINISTERED WITHOUT THE COMPLETION OF THIS FORM WITH PARENT/GUARDIAN SIGNATURE.**

I give permission to the school nurse, or designee, to administer the medication that I have provided as instructed on the medication container and/or administer treatment as prescribed in the Standing Orders from the physician.

\_\_\_\_\_  
**Name of Student**

\_\_\_\_\_  
**Grade**

**Allergies:**    Yes [  ]        No [  ]        Please List

\_\_\_\_\_  
**Name of Medication & Dose**

\_\_\_\_\_  
**Reason for taking**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Physician**

\_\_\_\_\_  
**Physician's Phone #**