Saint Thomas Aquinas Regional Catholic High School
14520 Voss Drive • Hammond, LA 70401
985-542-7662 • www.stafalcons.org

**PARENTAL CONSENT FOR MEDICATION ADMINISTRATION**

Please give my child, ________________________________________, the medication as ordered below by

Dr. __________________________________________________.

I accept the rules of the school concerning the giving of medication, including the following:

- The medication must be prescribed by a physician, who must also certify in writing that it is NECESSARY for the child to receive the medication during school hours. This certification shall be obtained by having the physician complete and sign the form below.
- The medication must be brought to school by an adult in a container with the label from the pharmacy, showing the name of the medication, dosage, child's name, and the time to be given. Supply must not exceed one month's supply. The container will be sent home when empty.
- This school or designated person administering the medication are held harmless for any unintentional mistakes or oversights in keeping or giving my child's medication.

Medication administered at home:

Time __________________ Dosage _____________________ Duration _________________________

_____________________________________________________________
Parent or Guardian Signature

Parent or Guardian Phone 1 _____________________________ Phone 2 _________________________________

**__________ SCHOOL HAS PERMISSION TO ADMINISTER ACETOMINOPHEN OR IBUPROFEN WITHOUT NOTIFYING PARENT OR GUARDIAN**

## PHYSICIAN ORDER FORM

**To Be Completed by Physician ONLY**

**I HEREBY CERTIFY THAT IT IS NECESSARY FOR THE MEDICATION LISTED BELOW TO BE GIVEN DURING SCHOOL HOURS TO:** ______________________________________

Name Of Medication __________________________ Diagnosis ___________________________

Amount of Dosage ___________________________ Time to be given _____________________

Date to Begin _______________________________ Date to End _________________________

Comments ____________________________________________________________________

_____________________________________________________________________________

Physician Signature ________________________________________ Date ______________________

Office Telephone ________________________________________________