School Year: 2016-2017
(Consent is for the above school year only)

School/Center: St. John Francis Regis School
Address: 8941 James A. Reed Rd
Kansas City, MO 64138
Phone & Fax: Ph: 816-763-5837 Fax: 816-966-1350

Consent for Medication

HEALTH CARE PROVIDER CONSENT:

As school/center personnel, we must have a health care provider's order before we are permitted to give any medications. This permission must be in written form and on file with this school/center's office. A new, signed form is required each school year.

Student/Child Name: _____ Date of Birth: _____

Diagnosis/Reason for Medication(s) (prescription and over-the counter): _____
_____

The above named student/child may receive:
◊ Prescription medication according to label instructions (Prescription label serves in lieu of physician's order)
◊ Non-prescription medication as directed:
> Acetaminophen _____
> Ibuprofen _____
> Cough Drops/throat lozenges _____
> Anti-itch lotion _____
> Allergy medication _____
> Other _____

SPECIAL INSTRUCTIONS/COMMENTS: _____
_____

I request and authorize that the above named student/child be administered the above medications as directed while in school/center.

_____ _____
Doctor/Health Care Provider's Signature **Date**

_____ _____
Telephone Fax

<u>PLEASE NOTE</u>: MEDICATION CANNOT BE DISPENSED FROM UNLABELED CONTAINERS. ALL PRESCRIBED MEDICATION MUST BE SENT IN A LABELED PRESCRIPTION CONTAINER FROM THE PHARMACY. ALL OVER-THE-COUNTER MEDICATION MUST BE PROVIDED IN THE ORIGINAL MANUFACTURER'S CONTAINER AND LABELED WITH THE STUDENT/CHILD'S NAME AND DOSAGE. EXPIRED MEDICATIONS CANNOT BE ADMINISTERED.

STUDENTS/CHILDREN ARE NOT ALLOWED TO CARRY MEDICATIONS (PRESCRIPTIVE OR OVER-THE-COUNTER) WITH THEM. ALL MEDICATIONS ARE TO BE KEPT WITH SCHOOL/CENTER STAFF MEMBERS. STUDENTS/CHILDREN WITH PROPER AUTHORIZATION MAY BE ALLOWED TO CARRY AND SELF-ADMINISTER ASTHMA OR OTHER MEDICATIONS FOR LIFE THREATENING CONDITIONS. (Contact the school/center staff for more information).

PARENT/GUARDIAN PERMISSION: I hereby give my permission for designated school/center personnel to administer the medication described above as directed by the licensed health care provider. I accept responsibility for immediately notifying the staff of any change in these instructions. Further, I indemnify and hold harmless this school/center, parish, the Kansas City-St. Joseph Diocese and its employees or agents against any claim from the use of this/these medications.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE