

Our Lady of Perpetual Help School

6686 Streeter Avenue

Riverside, Ca. 92504

951-689-2125

Fax 951-689-9354

One form per medication to be given during school/after care.

Request for Medication to be taken during school hours

This form must be renewed each school year

To be completed by parent: (for all medications)

Name of student: _____ Grade: _____

name of medication Dose time(s) to be given number of days

I request that my child, named above, be assisted in taking the prescribed medication at school by authorized persons. I agree to comply with the school's policies and procedures. I have provided the medication in its original container and labeled as above.

_____ Date _____ Daytime telephone number _____ Parent/Guardian signature

To be completed by a licensed physician: for all medications, including over the Counter

_____ Name of medication _____ Purpose of medication

_____ Date Prescribed _____ Dosage _____ Frequency _____ Duration

Precautions, special instructions, possible side effects, comments:

_____ The student named above , for whom this medication is prescribed, is under my care.

_____ Print name of physician _____ Signature of Physician

_____ Date _____ Telephone number

Please Log Medication Administration on Reverse Side

Medication Administration Log

Grade: _____

Year: _____

Student: _____ / Initials: _____ Medication: _____ Dosage: _____ Time(s) to be given: _____

Directions: For each day a medication is administered enter your initials in the date box corresponding with the correct month.

Use the key to document reasons the medication was not given.

If more than two doses are given on the same day, draw a diagonal line through the square and initial each area as given.

Draw a line or x through the unused dates.

Maintain this form for three years after the student will turn 21.

Key: A: absent, X: school not in session, D/C: discontinued, N/A: Not available, R: refused, M: missed

month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
Oct																															
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Feb																															
March																															
April																															
May																															
June																															

Persons Administering Medications

Printed Name	Signature	Initials	Title	Date