MEMORANDUM

TO: ALL PARENTS AND GUARDIANS

FROM: MRS. HETZLER

SUBJECT: MEDICATIONS

DATE: 2014-2015 SCHOOL YEAR

On the reverse side of this memo is our "Medication Information" Form. For the safety of every student, we must file a health record of any medication that a student takes on a regular basis. This form provides us with knowledge of the drugs, dosage, and any possible side effects. In the event of an emergency at school, we would also have this information readily available. For example, if an EMT had to be called and they asked what medications the child takes, we would have the information on file. We appreciate your cooperation with this matter. If you have any questions, please feel free to call me at 367-3601 ex. 108.

Please note:

- This form must be returned signed for every student who attends Christ the King School.
- Medications include over the counter drugs if they are taken daily.

SEE REVERSE

CHRIST THE KING PARISH SCHOOL
PARENT/GUARDIAN WRITTEN CONSENT
FOR MEDICAITON ADMINISTRATION

GENERAL INFORMATION

NAME OF STUDENT:_____ HOMEROOM:_____
DATE OF BIRTH:_____ SEX:_____

NAME OF PARENT OR GUARDIAN:_____PHONE (HM):_____

ADDRESS:_____PHONE(WK):_____

OTHER PERSONS TO BE NOTIFIED, IN CASE OF AN EMERGENCY, IF PARENT/GUARDIAN IS UNAVAILABLE:

NAME:_____PHONE:(HM)_____(WK)_____

RELATIONSHIP:_____

NAME:_____PHONE: (HM)_____(WK)_____

RELATIONSHIP:_____

STUDENT ALLERGIES: (List medication, food, etc.)_____

PARENT/GUARDIAN CONSENT

1. I hereby give permission for the school nurse or the designated unlicensed person trained to administer medication at school, to give the following medication:_____
   to _____ prescribed by _____.
   (Name of Student) (Name of Doctor/Dentist)

2. I give permission to the school nurse to share with appropriate school personnel information (such as adverse side effects) relative to the prescribed medication administration as the nurse determines necessary for my son's/daughter's health and safety.

3. I understand that I may personally retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within two weeks following termination of the Physician's order or two weeks beyond the end of the current school term.

4. I have administered the initial dose ordered at home to my child and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication.

I have read, understand, and agree to the school's regulations concerning giving medication at school.

_____ _____
Date Signature of Parent/Guardian