



Our Lady of Prompt Succor School  
 2305 Fenelon Street  
 Chalmette, LA 70043  
 (504)271-2953



**PRESCRIPTION MEDICINE REQUEST FORM**  
 (Please print clearly)

I \_\_\_\_\_ authorize the office staff of Our Lady of Prompt Succor School to dispense the following Medication(s) to my son/ daughter.

**Medication Name:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Dosage:** \_\_\_\_\_

\_\_\_\_\_

**Time to be dispensed:** \_\_\_\_\_

\_\_\_\_\_

Prior to dispensing any medication, the following must be accomplished:

1. A note from the physician must be sent to the office with the following information thereon. Name of Patient, Name of Medication, and dosage to be dispensed.
2. This form is completed by a parent/guardian.
3. All medications must be sent in pre-measured doses clearly marked with the child's name thereon.

I have read the above and agree to hold harmless the faculty and staff of Our Lady of Prompt Succor School for any complications arising from the execution of the instructions indicated hereon.

\_\_\_\_\_  
 Parent's Printed Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent's Signature

Student's Name: \_\_\_\_\_



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**PRESCRIPTION MEDICATION ADMINISTRATION  
 CONSENT FORM (Please print clearly)**

Student name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**PRACTITIONER SECTION**

Practitioner name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of medication & strength (e.g., mg.): \_\_\_\_\_ Time to be given: \_\_\_\_\_

Dose & route of administration: \_\_\_\_\_ How often: \_\_\_\_\_

Reason for medication: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Considerations/side effects: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Duration: From \_\_\_\_\_ to \_\_\_\_\_

For an as-needed (PRN) medication, state specific conditions under which medication is to be given:

State the side effects for which we should contact you:

NOTE: Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by non-medically trained designee(s) and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in the language of the lay person. Any changes to this order must be in written form.

Practitioner's Signature \_\_\_\_\_ Date \_\_\_\_\_