**Cardinal Newman High School**

(561) 683-6266, FAX (561) 683-7307

**FOR USE IN TIMES OF ILLNESS AND REGULARLY SCHEDULED MEDICATIONS FOR YOUR CHILD**

AUTHORIZATION FOR STUDENT MEDICATION

**Name of Student/Grade:** ____________________ **Birthdate:** ____________

**Diagnosis:** ____________________ **Any Known Allergy (Food or Drug)** ____________

**Name of Medication:** ____________________ Date to be Discontinued: ____________

Dosage: ____________ Specific Time: ____________ Frequency: ____________
(Amount to be Given):
Form of Medication (Circle):
1. Oral 2. Injectable 3. Inhaler 4. Other (Specify) ____________
Location of medication: ____ Stored in Health Room ____ Carried on Person (Epi-Pen, Inhaler) ____ Other (Specify)
Desired action of medication: ____________
Symptoms of adverse reaction to medication: ____________
Does the student take above medication or any other medication at home? Yes ____ No ____
If yes: Medication ____________ Dose ____________ Frequency ________

**Physician Authorization** (Needed for prescribed medication and over the counter medications)

- The student has been trained and has my permission to self administer the prescribed medication (epi-pen, insulin, asthma inhalers and nebulizers only) if the school nurse determines it is safe and appropriate. YES_____ NO ______
- The parent knows of this request and has agreed to provide the supplies needed for the above medication.
- Should the student manifest any of the above symptoms which may be caused by the medication, I understand that the parent will be contacted and the School Health Directives relating to emergency care will be followed.

____________________ ____________________ ____________
Physician's Name (Print) Physician's Signature Date

____________________ ____________________
License # Telephone #

**Parent Permission**

I Understand That:

- Medication orders are valid for one school year only and need to be renewed at the beginning of each school year.
- Medication(s) must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication(s) as needed.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I understand I may retrieve the medication from the school at anytime; however, the medication will be destroyed if it is not picked up within one week following termination of the order or two days beyond the close of the school year.

I hereby give my permission for my child (named above) to receive medication during school hours supervised by the nurse or administration designee. I understand that Cardinal Newman undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release Cardinal Newman High School and its agents, volunteers and employees from any and all liability that may result from my child taking the medication.

____________________ ____________ ____________________
Parent/Guardian Signature Date Home/Emergency Phone # (Work, Cell, Beeper)

Signed before me this ____________ day of ____________ in the year of ____________.

The State of ____________. The County of ____________.

SEAL ____________________ ____________________
(Notary's Signature) (My Commission Expires)