ST. STEPHEN SCHOOL

Medication Administration Form & Directions

Student Information

First Name: _____ Last Name: _____

Date of Birth: ____/____/_____

Parent/Guardian Information

First Name: _____ Last Name: _____

Cell Phone: (_____)_____ Home Phone: (_____)_____

Street Address:_____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

I hereby request and authorize school personnel to administer my child's prescribed medication as directed by our doctor.

> "Administration of medication to pupil; liability. A school administrator, teacher or other school employee designated by the school administrator, who in good faith administers medication to a pupil in the presence of another adult pursuant to written permission of the pupil's parent or guardian and in compliance with the instructions of a physician is not liable in a criminal action or for civil damages as a result of the administration except for an act or omission amounting to gross negligence or willful and wanton misconduct."
>
> Michigan Compiled Laws, 19822 (380.1178)

Parent/Guardian Signature: _____ Date: _____

Doctor Information and Orders

I _____ authorize/prescribe that _____

(Doctor's Full Name) (Student's Full Name)

is to receive his/her medication _____ in the amount of

(Name of Medication)

_____ daily or as follows _____.

(dosage-mg)

Duration: _____ Possible side effects: _____

Doctor Signature:_____ Phone #: (_____)_____

IMPORTANT: The medication must be brought directly to school by the parent. Most pharmacies will provide a duplicate container, if requested.

PLEASE NOTE: The school is NOT under any obligation to administer medication if it does not wish to. If children carry medication on their person or in their lunch St. Stephen School WILL NOT BE RESPONSIBLE.