ROMAN CATHOLIC
DIOCESE OF CHARLESTON

AUTHORIZATION TO ADMINISTER MEDICATION

CHILD/WARD: _____

SCHOOL: _____

SCHOOL YEAR: _____

NOTE TO PARENTS/GUARDIANS:
We attempt to discourage administration of medications during SCHOOL hours. We request that whenever possible, medication be scheduled during non-SCHOOL hours. However, we understand that there are situations of emergency which necessitate the administration of such medicine. Information shall be shared with staff on a "need to know" basis. The SCHOOL (understood to include BISHOP OF CHARLESTON A CORPORATION SOLE) requires compliance with the following regulations for students who need medication during SCHOOL hours.

1. All medication shall be delivered by the parent/guardian to the SCHOOL nurse/teacher.
2. A written consent form signed by the parent or guardian is required before medication can be given.
3. Initial doses of a medication that a child has never taken before should not be given at SCHOOL.
4. A separate form must be completed for each medication.
5. Medication should be limited to no more than a 31-day supply.
6. SCHOOL may decline to administer certain medications if deemed inappropriate for SCHOOL settings. In that event, the parent and health care practitioner will be notified.
7. When medication must be administered during a field trip or other off-campus SCHOOL activity, the medication shall be transported by the staff designated to administer the medication.

Part I: To Be Completed By The Prescribing Health Care Provider:

Child's Name:_____ Date of birth: _____ Grade: _____
Medication: _____ Dosage:_____
Purpose of medication: _____ Route: _____
Time of medication: _____ Frequency: _____
Note special storage requirements: (check one) __None __Refrigerate __Other(specify)_____
_____
Anticipated number of days medication will be given at SCHOOL: _____
_____
Is child allergic to any food, medicines, or other items? If so, please list allergies) _____
_____
Is this medication a controlled substance? __Yes __No
Possible side effects: _____
_____
_____

Prescribing Health Care Provider's Signature: _____Date:_____
Print or Type Health Care Provider's Name & Address:_____
_____
Office Phone Number: _____ Office Fax Number: _____

Part II: To Be Completed By the Parent(s)/Guardian of the Child:

I _____ the parent/guardian of _____ request and give permission to SCHOOL nurse, the principal or the principal's designee be caretaker of and administer the medication described above to my child as prescribed. I give permission for the SCHOOL teacher or SCHOOL administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the above health care provider and pharmacist and/or their designated employees to provide information about this medication and my child's health to the SCHOOL nurse or administrator. I understand that the SCHOOL may require that I agree to the SCHOOL's rules about medication before this medication will be given at SCHOOL.

I understand and acknowledge that the SCHOOL does not employ a full time nurse and that the medication would be administered by a lay person, to the best of his/her ability. I also understand and acknowledge that the SCHOOL will not provide medical training to the person who will administer the medication. As the parent of the child I understand that I have the option of providing medical training at my own expense to the person who will administer the medication to the child.

I agree to assume responsibility for all the risks associated with the administration of this medicine by the SCHOOL to my child, whether identified above, or not (EVEN THOSE RISKS ARISING OUT OF THE NEGLIGENCE OF THE SCHOOL). I assume full responsibility for myself and for my child for whom I am responsible for any injury, accident relating to this authorization. I hereby release the SCHOOL (understood to include BISHOP OF CHARLESTON A CORPORATION SOLE) its principals, directors, officers, agents, employees and volunteers, their insurers and each and every land owner, municipal and/or governmental agency upon whose property and activity is conducted FROM ANY AND ALL LIABILITY OF ANY NATURE FOR ANY AND ALL INJURY OR DAMAGE TO ME, MY CHILD AND OTHER PERSONS as a result of my request to SCHOOL to administer the listed medicine to my child, EVEN IF CAUSED BY THE NEGLIGENCE OF ANY OF THE SCHOOL'S EMPLOYEES OR REPRESENTATIVES.

I will not hold the SCHOOL or the SCHOOL personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I will notify the SCHOOL if my child's medication changes

I HAVE READ THIS ASSUMPTION AND ACKNOWLEDGMENT OF RISKS AND RELEASE OF LIABILITY. I UNDERSTAND THAT BY SIGNING THIS DOCUMENT, I AM WAIVING VALUABLE LEGAL RIGHTS, INCLUDING ANY AND ALL RIGHTS I MAY HAVE AGAINST THE SCHOOL, OR ITS EMPLOYEES, AGENTS, SERVANTS OR ASSIGNS.

_____ _____

Signature of parent/Guardian Date

_____ _____

Print of Type Name of Parent/ Guardian Cell/Day Phone Number