PRESCRIPTION Medication Permission Form

Notice to Parents of Students Who Require Administration of Prescription Medication

Students who require prescription medication must bring the **medication in the properly labeled, original prescription bottle** along with this Prescription Medication Permission Form completed and signed by a legal parent or guardian **(and physician)** to the school office. All medications are kept in the office safe.

Columbus Catholic Schools' office personnel will administer medications. No medications will be given to students unless the items listed below are completed. Medications will remain at school (please have a separate bottle at home) and will be sent home with the student when empty. Students are responsible for coming to the office to receive medication at the designated time. If a student refuses to take the prescribed medication, the parent/guardian will be notified immediately. If you have any questions regarding medication administration procedures, please contact your school office.

Any student who is in need of carrying an inhaler or EpiPen must have a separate form signed by a licensed prescriber/physician. You may request this form at the school office.

Parent Permission Form

(This section is to be completed by the parents.)

Student's Name _____ Telephone Number _____

School Select your school Grade __ Date of Birth_____

Parent/Guardian Names _____

I hereby authorize Columbus Catholic Schools' designated staff to administer medication to my son/daughter as indicated below by the prescribing physician. I will notify the school in writing if there are any changes to the medication. A new form is necessary if there is a change in prescription and/or dosage. I further agree that I will not hold designated school personnel responsible for any claims arising from the administration of medication at Columbus Catholic Schools.

This section is to be completed by the prescribing physician.

In order for Columbus Catholic Schools to accurately distribute medication, please complete the following information.

Medication	**Dose**	**Time to be given**	**Duration (entire school year, 10 days, etc.)**

Any side effects or concerns _____

Physician Signature _____*Date* _____ *Telephone* _____

Parent/Guardian Signature_____ Date _____

End of Year medication instructions (please check one):

_____ I will pick up the medication on the last day of school.

_____ Please send the medication home with my child on the last day of school.

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