

ARCHDIOCESE OF NEW ORLEANS

Request for School Personnel to Administer Medication

(Please complete all information on this form and return it to the school office. Thank You.)

1. Child's name _____ Grade _____

2. Medication to be administered _____

3. Dosage _____

4. Purpose of medication _____

5. Time of day medication is to be given _____

6. Anticipated number of days medication needs to be given during school hours

7. Possible side effects _____

(Signed physician statement must accompany this request form.)

My signature authorizes the school secretary, principal, or designee to administer the medication, as stated on this form, to my child, _____, and that any side effects from the medication are not the school's responsibility.

Date _____

Parent's Signature _____