SAINT IGNATIUS

Cleveland · Jesuit · 1886

Prescribed Medication Permission Form

To be completed by the Authorizing Prescriber

_____

Student's last Nam First Name DOB Grade

_____

Name of Medication

Form of Medication: _____ Tablet/Capsule _____Inhaler ____ Injection _____Other

Is this medication for Emergency events only (i.e. Anaphylaxis): Yes ____ No ____
(Also need to complete Emergency Allergy Action Plan for epinephrine use)

Dose to be taken: _____

Frequency to be taken/directions: Start date: _____ End date: _____

_____

Restrictions &/or Important Side effects: Check here if none: _____

_____

Check here ____if this release is for a **metered dose asthma inhaler**, which the student will possess and use at his own discretion in school or at school activities. ***(Also need to complete Asthma Action Plan)***

Physician's Signature: _____Date: _____

Printed Name: _____ Phone: _____

To be completed by Parent/Guardian

I/we request, as legal guardian(s), that my son_____ be able to access and self-administer, when appropriate and necessary, the above prescribed medication during school hours or other school-sponsored events or trips. I understand it is my responsibility to provide the medication in its original container and to notify the school of any change or discontinuation of the medication. I hereby waive any liability whatsoever against Saint Ignatius High School or any of its personnel, employees, agents and volunteers which might occur in relation to the provision and self-administration of said medication in the dosage and frequency as prescribed above to my son. I/we consent to allow my son to self-administer the above prescribed medication made available to him by school staff and have completed the necessary self-administration waiver and release. I give permission to the School Nurse to communicate with the prescriber regarding my son's treatment plan.

Parent/Guardian Signature _____ Date_____

Printed Name: ______________________________________ Phone: ____________________