Lebanon Catholic
SCHOOL

LEBANON CATHOLIC SCHOOL
NURSE'S OFFICE
1400 Chestnut Street, Lebanon, PA 17042
Phone: 717-273-3731 Fax: 717-274-5167
Website: www.lebanoncatholicschool.org

AUTHORIZATION FOR PRESCRIPTION MEDICATION (CONFIDENTIAL)

Name of Student__________________________________ Date of Birth___________

School____ Grade________________

Medication____

Time(s) of day medication is to be given_______________________________________

The Physician's written authorization, including all necessary instructions for administering the medication, must accompany this request.

Special instructions by Parent/Guardian_______________________________________

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Has the first dose of this medication been given? YES NO

***School personnel are prohibited from giving the first dose of any medication.*

I understand that some prescription medications, which may include the above listed medication, might cause my child to suffer an adverse reaction or other serious medical condition. I hereby release, waive, discharge and covenant not to sue the Diocese, Parish, School or their employees, officials, agents or volunteers for any liability for damages, injury or death that may result from ill effects or adverse reactions to this medication.

I authorize this medication to be administered at the School by staff persons or volunteers who are not physicians, licensed registered nurses (RNs), or licensed practical nurses (LPNs). I understand, acknowledge and approve that the individuals administering the medication do not have any form of medical license and will not perform a medical assessment of my child prior to administering the authorized medication.

Further, I acknowledge that the School bears no responsibility for ensuring the medication is administered and that the Diocese, Parish, School or their officials, employees, agents or volunteers may decline to administer the medication. If the School declines to administer the medication, the School will take reasonable steps to notify you that the medication will not be administered.

I HEREBY CERTIFY THAT I HAVE READ THIS DOCUMENT IN FULL AND THAT I HAVE THE LEGAL AUTHORITY TO CONSENT TO THE ADMINISTRATION OF THIS MEDICATION.

Date_____________ Signature of Parent/Guardian________________________

Printed Name____________________________________

Date_____________ Witness (School Employee)_________________________

Printed Name____________________________________

NOTE:

A physician's written authorization must accompany this request, and the medication must be provided to the school in the original container, with a legible label.

<u>THIS RELEASE IS TO BE RETAINED IN STUDENT'S MEDICAL FILE.</u>

Licensed Prescriber Medication Order:

Patient's name: ____Date: ___________________

Name of medication: ____

Route and dosage: ____

Time of administration: ____

Directions: ____

____

Discontinuation date: ____

Allergies: ____

Licensed Prescriber signature: ____

Licensed Prescriber name printed: _____________________________Phone: _________________