Cleveland Central Catholic High School
Parental Request Form for Prescribed Medication (8/2017)

{Please return this document to the Guidance Office}

______________________________ __________ _________ __________

Student's Name Homeroom Grade Date of Birth

TO BE COMPLETED BY THE PARENT/GUARDIAN

I give permission for my child, _____________________________, to receive the medication below at school according to the Cleveland Central Catholic policy. It is understood that Cleveland Central Catholic and all its personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand the medication must be brought to school in the container in which the pharmacist dispensed it.

Date ___________ Parental/Guardian Name (printed) ____

Signature: _________________________________ Emergency phone number: _________________

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: ____

Name of medication: ____

Medicine Form: ___table/capsule ___liquid ___inhaler ___injection ___other ________________

Special Storage Requirements: ___refrigerate ___none ___other____________________________

Start Date: _______________ Stop Date: ___end of the year ___other/duration__________________

___for episodic/emergency events only

Instructions (schedule and dosage to be given) ____

____

Restrictions/Side effects: ____

____

Adverse reactions that should be reported to the physician: _______________________________________

____

If prescribing an epipen or rescue inhaler, is the student capable and responsible for self-administering it?

___No ___Yes (supervised) ___Yes (unsupervised)

May the student carry the epipen or rescue inhaler? ___Yes ___No

Procedure to follow in event medication does not produce the expected relief: ____________________

____

Date: ________ Printed Name: _________________________ Signature: _______________________

Address: ____ Emergency phone: _____________________