Diocese of Steubenville
Office of Christian Formation and Schools

DISPENSATION OF MEDICATION

SECTION A – To be completed by the parent

Student's name/birthdate _____ Name of School/Homeroom Teacher _____

Address _____ Telephone number (For Emergency contact) _____

We (I) the undersigned, who are the parent(s) guardian(s) of the above-mentioned child, request that the health care service, outlined below and prescribed by the physician, be provided to our child. We(I) authorize the school to appoint a quãlified, designated person(s) to perform the prescribed treatment as directed by the physician. We (I) agree to notify the school personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician.

Parent's/guardian's signature _____ Date _____

SECTION B – To be completed by the physician

Parent's/guardian's signature _____ Date _____ Telephone number _____

Address _____

Name of the treatment/medication _____

Specific instructions for administration _____

Beginning date _____ Ending date _____

Adverse reactions that should be reported to the physician _____

Training necessary for lay personnel to administer treatment _____

Special storage instructions _____

Physician's signature _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER IN WHICH IT WAS DISPENSED.

LIMIT AMOUNT TO ONLY THAT WHICH IS NEEDED!!