CATHOLIC SCHOOLS - DIOCESE OF GALVESTON-HOUSTON
REQUEST FOR IN-SCHOOL ADMINISTRATION OF MEDICATION (HF-7.0)

NOTE TO PARENTS/GUARDIANS:

Clinic personnel are not permitted to give medication of any kind, prescription or non-prescription, unless the physician requests in writing that there is a need for such medication. The doctor's statement must be accompanied by written permission of at least one parent.

TO THE DIRECTOR OF DECATS:

NAME OF SCHOOL CHILD _____ BIRTHDATE _____

In order to keep this school child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours.

Name of medication _____

Reason medication prescribed _____

Tablet Pill Capsule Liquid Inhalation

Other (specify): _____
Dosage (amount to be given): _____
How often or at what time: _____
Date discontinued: _____

_____
Physician's Signature Phone number

_____
Physician's Name (PRINT)

I agree to hold the school harmless for the proper administration of medication provided by the parent/guardian and for adverse drug reactions or side effects.

I agree to be responsible for maintaining an adequate supply of medication at the school to meet the child's needs.

Parent/Guardian _____ Home phone _____

Today's Date _____ Work phone _____

FORM ONLY REQUIRED IF MEDICATION MUST BE DISPENSED!