# Archdiocese of Miami

**School Name**

# PRESCRIPTION MEDICATION RELEASE FORM

**PARENT REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

In order for **SCHOOL NAME** personnel to dispense medication to your child, this completed form, along with the medication is to be brought to the school by the parent or student. Prescribed medication/treatment may be administered by designated school personnel. The medication should be brought to the school in the original container appropriately labeled by the pharmacy.

**NOTE:** Prescribed asthma inhaler may be kept by the student and self-administered if a physician indicates the need in writing and considers the student sufficiently responsible. In addition, the physician should list any precautions to be followed on this form.

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| **Student Name:** |  | **ID:** |  |
| **Grade:** |  |

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| --- |
| **Allergies:** |
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| --- | --- |
| **Name of Medication:** |  |
| **Reason for Medication:** | |
|  | |
| **Dosage:** |  |
| **Form of Medication/Treatment:** | 🞏 Tablet/Capsule 🞏 Liquid 🞏 Inhaler 🞏 Injection 🞏 Nebulizer  🞏 Other: |
| **Time Medication is given:** |  |
| **Restrictions and/or**  **Important Side Effects:** | 🞏 None anticipated 🞏 Yes, please describe: |
| **Special Storage Requirements:** | 🞏 None 🞏 Refrigerate 🞏 Locked storage |
| **Special Administration Procedures:** | 🞏 None 🞏 Crush pill 🞏 With Food |
| **Start Medication Date:** |  |
| **Stop Medication Date:** |  |

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| --- | --- | --- | --- |
| I, the undersigned, the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request that the above medication or procedure be administered to my child. I release the school personnel and the school district from liability stemming from adverse reactions and all other adverse effects which may occur because of administering the aforementioned medication. | | | |
| **Parent/Guardian signature:** |  | **Date:** |  |