ST. JEAN VIANNEY CATHOLIC SCHOOL

16266 S. Harrell's Ferry Road • Baton Rouge, Louisiana 70816 • (225) 751-1831 • FAX (225) 752-8774

PARENTAL CONSENT FOR MEDICATION ADMINISTRATION

Please give my child, _____,
(Name of Child)

the medication as ordered below by Dr._____.

I accept the rules of the school concerning the giving of medication, including the following:

1) The medication must be prescribed by a physician, who must also certify in writing that it is **NECESSARY** for the child to receive the medication during school hours. This certification shall be obtained by having the physician complete and sign the form below.
2) The medication must be brought to the school by an adult in a container with label from the pharmacy, showing name of medication, dosage, child's name and the time to be given. Supply must not exceed one months supply. The empty container will be sent home.
3) This school or designated person administering the medication are held harmless for any unintentional mistakes or oversight in keeping or giving my child's medication.

Medication administered at home: Time(s):_____
Dosage:_____
Duration:_____

_____
(Parent or Guardian Signature)

Parent or Guardian Address_____
Home Telephone #: _____ Work Telephone : _____

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PHYSICIAN'S ORDER FORM

TO BE COMPLETED BY PHYSICIAN ONLY.

I HEREBY CERTIFY THAT IT IS NECESSARY FOR THE MEDICATION LISTED BELOW TO BE GIVEN DURING SCHOOL TO: _____.

Name of medication: _____ Diagnosis _____
Amount of dosage: _____ Time to be given:_____
Date to begin: _____ Date to end:_____
Comments:_____
_____

Physician's signature: _____ **Date:**_____
Office telephone #: _____