



School Year: 2023-2024
(Consent is for the above school year only)

School/Center: St. Regis Academy
Address: 8941 James A. Reed Rd.
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Consent for Medication

HEALTH CARE PROVIDER CONSENT:

As school/center personnel, we must have a health care provider's order before we are permitted to give any medications. This permission must be in written form and on file with this school/center's office. A new, signed form is required each school year.

Student/Child Name: _____ Date of Birth: _____

Diagnosis/Reason for Medication(s) (prescription and over-the counter): _____

The above named student/child may receive:

◇ Prescription medication according to label instructions (Prescription label serves in lieu of physician's order)

◇ Non-prescription medication as directed:

> Acetaminophen _____

> Ibuprofen _____

> Cough Drops/throat lozenges _____

> Anti-itch lotion _____

> Allergy medication _____

> Sunscreen _____

>Other _____

SPECIAL INSTRUCTIONS/COMMENTS: _____

I request and authorize that the above named student/child be administered the above medications as directed while in school/center.

Doctor/Health Care Provider's Signature

Date

Telephone

Fax

PLEASE NOTE: MEDICATION CANNOT BE DISPENSED FROM UNLABELED CONTAINERS. ALL PRESCRIBED MEDICATION MUST BE SENT IN A LABELED PRESCRIPTION CONTAINER FROM THE PHARMACY. ALL OVER-THE-COUNTER MEDICATION MUST BE PROVIDED IN THE ORIGINAL MANUFACTURER'S CONTAINER AND LABELED WITH THE STUDENT/CHILD'S NAME AND DOSAGE. EXPIRED MEDICATIONS CANNOT BE ADMINISTERED.

STUDENTS/CHILDREN ARE NOT ALLOWED TO CARRY MEDICATIONS (PRESCRIPTIVE OR OVER-THE-COUNTER) WITH THEM. ALL MEDICATIONS ARE TO BE KEPT WITH SCHOOL/CENTER STAFF MEMBERS. STUDENTS/CHILDREN WITH PROPER AUTHORIZATION MAY BE ALLOWED TO CARRY AND SELF-ADMINISTER ASTHMA OR OTHER MEDICATIONS FOR LIFE THREATENING CONDITIONS. (Contact the school/center staff for more information).

PARENT/GUARDIAN PERMISSION: I hereby give my permission for designated school/center personnel to administer the medication described above as directed by the licensed health care provider. I accept responsibility for immediately notifying the staff of any change in these instructions. Further, I indemnify and hold harmless this school/center, parish, the Kansas City-St. Joseph Diocese and its employees or agents against any claim from the use of this/these medications.

PARENT/GUARDIAN SIGNATURE

DATE