

St. Michael School
3431 St. Michael Blvd., N.W.
Canton, OH 44718
(330) 492-2657

DISPENSATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

SECTION A – To be completed by the parent

Child's name/birthdate

School district/school/classroom

Address

Telephone number

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 qualified, 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

Physician's printed name

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 _____

Treatment 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!!