ARCHDIOCESE OF NEW ORLEANS

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

(Please complete all information on this form and return it to the school office. Thank you.)

1. Child's name _____ Grade _____
2. Medication to be administered _____
3. Dosage _____
4. Purpose of medication _____

_____

5. Time of day medication is to be given _____
6. Anticipated number of days medication needs to be given during school hours

_____

7. Possible side effects _____

(Signed physician statement must accompany this request form.)

My signature authorizes the school secretary, principal, or designee to administer the medication, as stated on this form, to my child, _____, and that any side effects from the medication are not the school's responsibility.

Date _____

Parent's Signature _____