## CATHEDRAL SCHOOL MEDICATION/PROCEDURE FORM

STUDENT INFORMATION	(to be filled out by Parent/Guardian)	
Student's Name	Birthdate	School
Medication/Procedure	Dosage	Time/Frequency
School Year or Effective Dates	Student's Physician	
Reason for Medication/Procedure		PHOTO ID (Optional)
Medication allergies		
<u>NOTE</u> For prescription med	ication: Signed Parent Consent and Signe	
PARENT CONSENT: Complete for EA	scription medication: Signed <u>Parent Con</u>	
(Please review the Cathedral School Ha	-	
I request that this med	dication/procedure be adn	ninistered at school.
Medication will be supplied in its original, properly labeled container.		
■ This order is in effect f	for this school year unless	otherwise indicated.
_	•	s and obtain a new physicians
order.	m winding jer en j en en ger	ona sacama nen proposano
	sonnel to exchange inform	ation verbally or in writing with
•		r the condition for which it is
_ '	strict (ACS) from any liabili	ity claims as a result of the
	medication or procedure o	
danimistration of this	medication of procedure c	as un cerea.
Date Parer	nt/Guardian Signature	Telephone Number
PHYSICIANS ORDER: Complete for		
The above medication procedure is to b	be administered during the schoo	l day in accordance with the above
instructions.		
Please contact me if the following symp	otoms occur:	
For Asthma inhalers ONLY Students m	ay carry inhaler in school:	
YES YES	NO	
Date Physi	cian's Signature	

K:\Office\2016-2017 School Year\[School Medication Procedure Form 2016-17.xlsx]Policy Sheet