Holy Cross High School

Administration of Prescription Medication Form

Per school policy, no prescription medication may be administered at school unless this form is completed and signed by the student's parent and physician. This form will be kept on file and updated each school year.

Medication should be sent to the office in the original container labeled with the child's name along with this form. The form may also be faxed to the school office at 859-655-2184 or emailed to office@hchscov.com. Please note that students are not permitted to carry or dispense their own medication.

Student's Name____

Medication to be Administered_________________________________

Time(s) Student is to Receive the Medicine__________________________

Dosage/Instructions____

Possible Side Effects____

Expiration Date of this Request_________________________________

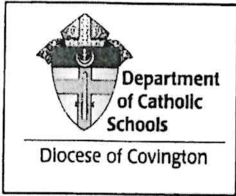
Physician's Signature_______________________________________

Physician's Phone Number_____________________________________

I hereby request and give my permission to the Holy Cross staff to administer the medication listed above to my child.

Parent Signature_____________________________ Date____________

Other notes/instructions:



DIOCESE OF COVINGTON
Department of Catholic Schools
Permission for student self-administration of asthma or anaphylaxis medication

Pursuant to the laws of the Commonwealth of Kentucky, ______________________________ School permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician, and waiver of liability by the parent/guardian.

To completed by parent/guardian:

Student name ____ Grade _____________

I/we authorize ______________________________________ School to allow the above-named student to self-administer asthma or anaphylaxis medication at school and school-related functions, according to the directions of the student's physician.

I/we release the school and its employees and agents from any and all liability as a result of any injury sustained by the student from the self-administration of this medication. I/we agree to indemnify and hold harmless the school and its employees and agents against any claims relating to the self-administration of asthma or anaphylaxis medication by the student.

Father/Guardian____ Date_____________

Mother/Guardian____ Date_____________

To be completed by the student's physician:

I have prescribed asthma or anaphylaxis medications for the above-named student and the student has been instructed in self-administration of that medication.

Name of the medications ____

Prescribed dosage____

The time(s) the medications are regularly administered ______________________________

____

Special circumstances under which the medications are to be administered

____

Length of time for which the medications are prescribed ______________________________

Physician's signature____________________________________ Date_________________

APPROVED while at Holy Cross High School

Principal____ Date_________________

Over the Counter Medication

We have the following over the counter medication if your child needs these during the day:

- Antacid Tablets
- Acetaminophen 500mg
- Ibuprofen 200mg

Please indicate by filling in the blanks if we can dispense the over-the-counter medication throughout their time at Holy Cross HS.

I give my permission for ____________________ to give the following medications

Medication: _____________ dose ______ hours: ____________

Medication: _____________ dose ______ hours: ____________

Medication: _____________ dose ______ hours: ____________

Parent Signature: _______________________ Date: ___________