Saint Catherine of Siena School

MEDICATION ADMINISTRATION FORM

(For all prescription **AND** over-the counter (OTC) medication)

Student Name_____ Grade: _____ DOB: _____

Medication Allergies: _____ Other Allergies: _____

This medication administration request is required by law for both prescription and over-the-counter (non prescription) medications. It is to be completed and signed by your child's health care provider AND parent. **This form must be renewed at the beginning of each academic school year and for each medication.

OVER-THE-COUNTER MEDICATION (OTC) **Must be in the original container with ALL labels intact.

Medication: _____ Dosage: _____ Frequency: : _____

Route: _____ Side Effects: _____ Date of Order: _____

Discontinue Date: _____ Reason for Medication: _____

PRESCRIPTION MEDICATION **Must be given as directed on the original prescription or original pharmacy label on the container.

Medication: _____ Dosage: _____ Frequency :____ _____

Route: _____ Side Effects: _____ Date of Order: _____

Discontinue Date: _____ Reason for Medication: _____

I give permission for the SCS school nurse to share information relevant to the medications above as necessary for my son/daughter's health and safety. **INITIAL:** _____

I understand ALL medication will be disposed of, if not picked up following the termination of the order, if the medication has expired or if it is not retrieved by the end of the academic school year. **INITIAL:**___

I give consent for the SCS school nurse to administer the above stated medication (OTC and Prescription) and to contact the prescribing physician regarding this medication order, if needed.

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Print Name: _____ **Daytime Phone Number:** _____

Parent Signature: _____ **Daytime Phone Number:** _____

Saint Catherine of Siena School
Health Office

EMERGENCY HEALTH CARE PLAN

Place Child's Picture Here

ALLERGY TO:_____

Student's Name:_____ D.O.B:_____ Teacher_____

Asthmatic Yes ☐ * No ☐ *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:**
• **MOUTH**	itching & swelling of the lips, tongue, or mouth
• **THROAT***	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
• **SKIN**	hives, itchy rash, and/or swelling about the face or extremities
• **GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
• **LUNG***	shortness of breath, repetitive coughing, and/or wheezing
• **HEART***	"thread" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

1. If ingestion is suspected, give _____
   Medication/dose/route
   and _____ immediately!
2. CALL RESCUE SQUAD:_____
3. CALL: Mother _____ Father: _____ or emergency contacts.
4. CALL: Dr: _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____ _____ _____ M.D. _____
Parent Signature Date Doctor's Signature Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation:_____ Phone:_____	1. _____ Room _____
2. _____ Relation:_____ Phone:_____	2. _____ Room _____
3. _____ Relation:_____ Phone:_____	3. _____ Room _____

Saint Catherine of Siena School
Health Office
249 Nahatan Street
Norwood, MA 02062
Phone / Fax: (781) 769-5455

Dear Parents / Guardians,

All children have a right to confidentiality especially when it involves their health records. Because of this right, we are not allowed to share pertinent medical information with our staff without **written** permission from a parent or guardian. We are trying to get our records and permission slips ready for the fall.

If you could, please take a moment and fill out the form for your child _____ and return it to school as soon as possible. The sooner we receive this information, the sooner we can inform our staff. (Of course, this is done only on a need to know basis.) If you have any questions or problems regarding this issue, please don't hesitate to call me at (781) 769-5354 extension 232 or (781) 769-5455.

Please remember that without this permission, no information regarding your child's health can be released. Thank you for your cooperation.

Lorna Maiona, RN

School Nurse

I,_____ give my permission for the school nurse to share pertinent medical information about my child, _____
first and last name
with his/her teachers and/or other school personnel that she determines should need to know this condition.

****

I,_____ **do not give** permission for the school nurse to share pertinent medical information about my child, _____.
first and last name

Date:_____

Saint Catherine of Siena School
Health Office

INFORMATION CARD

Place Child's Picture Here

STUDENT'S NAME:_____

TEACHER'S NAME:_____

GRADE:_____ ROOM:_____

FOOD ALLERGIES:_____

FOODS THAT CANNOT BE EATEN:_____

_____

_____

_____

_____

_____

_____ _____

Parent's Signature Date

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Health Office
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Norwood, MA 02062
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PARENT/GUARDIAN PERMISSION FOR THE ADMINISTRATION OF MEDICATION

Name of Student:_____ D.O.B.:_____

School:_____ Grade:_____

Name of Parent/Guardian:_____

Please Print

Address:_____

Telephone Number: (Home)_____(Work)_____

Known Allergies:_____

Other Medication your child takes:_____

CONSENT

1. I give permission to the school nurse or her designee to administer the following:

   _____ _____

   Medication *Dose*

   Measured as:_____

   Quantity (Teaspoon, tablet, puffs, etc.)

   Approximate time:_____

   Specific instructions:_____

   Start Date:_____ Stop Date:_____

2. This medication is being taken for:_____

   Reason

   Physician's name:_____

3. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child.

   Yes:_____ No:_____

   Any restrictions on release:_____

   (*Please note: I understand that I may retrieve the medicine from the school at any time, and that the medicine will be destroyed if it is not picked up within one week following termination of the order.)*

   Signature of Parent/Guardian:_____

   Date:_____

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Medication Order Form for Physician and Parent

To be completed by Physician:

It is necessary that the following medication be given during the school hours: Yes___ No___

Name of Student:_____ D.O.B.:_____

Medication:_____

Dosage/Route/Frequency/Time:_____

Start Date:_____ Stop Date:_____

Special Instructions/Possible Side Effects/Known Allergies:_____

_____

*Diagnosis (if not confidential): _____

_____ _____

Physician's Signature Date

_____ _____

Address Telephone

To be completed by the Parent/Guardian:

Student's Name: (print)_____ DOB:_____ Grade:____

Your Telephone: (home)_____ Cell/Work:_____

1. I give permission for the school nurse or her designee to administer the above named medication as prescribed.
2. This medication is being taken for:_____
3. List any other medication your child takes:_____
4. Physician's name: (please print)_____
5. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child.

   Yes:_____ No:_____

Please note: I understand that I may retrieve the medicine from the school at any time, and that the medicine will be destroyed if it is not picked up within one week following termination of the order.

Signature of Parent/Guardian:_____ _____

Please print Parent/Guardian Name

Date:_____

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To be completed by Physician:

It is necessary that the following medication be given during the school hours: Yes___ No___

Name of Student:_____ D.O.B.:_____

Medication:_____

Dosage/Route/Frequency/Time:_____

Start Date:_____ Stop Date:_____

Special Instructions/Possible Side Effects/Known Allergies:_____

_____

*Diagnosis (if not confidential): _____

_____ _____

Physician's Signature Date

_____ _____

Address Telephone

To be completed by the Parent/Guardian:

Student's Name: (print)_____ DOB:_____ Grade:____

Your Telephone: (home)_____ Cell/Work:_____

1. I give permission for the school nurse or her designee to administer the above named medication as prescribed.
2. This medication is being taken for:_____
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   Yes:_____ No:_____

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Medication:_____

Dosage/Route/Frequency/Time:_____

Start Date:_____ Stop Date:_____

Special Instructions/Possible Side Effects/Known Allergies:_____

_____

*Diagnosis (if not confidential): _____

_____ _____

Physician's Signature Date

_____ _____

Address Telephone

To be completed by the Parent/Guardian:

Student's Name: (print)_____ DOB:_____ Grade:_____

Your Telephone: (home)_____ Cell/Work:_____

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