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. Please note that only medication prescribed by a doctor may be administered at school. Thank you.

Child's Name _____Homeroom _____

Medication to be Administered _____

Dosage _____

Purpose of Medication _____

Time of Day Medication is to be Given _____

Anticipated Number of Days Medication Needs to be Given During School Hours_____

Possible Side Effects _____

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 Signature _____

Please see policy in handbook on administering medication.