SAINT BEDE ACADEMY MEDICATION SUPERVISION REQUEST FORM
Parent's Request / Doctor's Order

PARENT/GUARDIAN'S REQUEST – REQUIRED

Student Name_____

Student Address_____

Birth Date _____ Year in school (circle) 9 10 11 12

Parent Phone #_____ Emergency Phone #_____

I, the parent/guardian, acknowledge that I am **primarily responsible** for administering medication to my child. In the event that I am unable to do so I, the parent/guardian, request that **medication listed below** be stored safely and given to my child with supervision at school &/or my child be responsible for and be allowed to carry on their person and to self-administer an **inhaler, diabetic supplies, or Epi-Pen**.

In consideration for my student being allowed to take medication at Saint Bede Academy, I hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS Saint Bede Academy and their employees and agents, from any and all liability, for injuries, damages, medical expenses, or any other loss (including attorneys' fees) arising from or related to the supervision of my student taking medication listed below.

Parent Signature_____ Date_____

DOCTOR'S ORDER – REQUIRED

Name of Medication_____

Date this medication should Begin_____

Date this medication should End_____

Time/s to be Administered_____

Dosage and Route_____

Student's Diagnosis_____

Purpose of the Medication_____

Possible Side Effects, if known_____

Other Medication/s student is taking_____

If applicable, circle one: Inhaler Diabetic Supplies Epi-Pen

* If your student has been diagnosed with asthma, diabetes, or severe allergies by a licensed healthcare professional, a copy of the **Emergency Action Plan** needs to be on file with the main office prior to the first day of school or if diagnosed at a later date, after diagnosis.

SELF-ADMINISTERED MEDICATIONS: Student should be allowed to self-administer an inhaler, diabetic supplies or Epi-Pen. Student understands their diagnosis and the purpose of the medication. Student understands how to and is responsible for safely storing, carrying on their person and independently administering medication. Student understands the necessity to report to school personnel any unusual side effects or event.

If applicable, circle one: YES NO

Physician Signature_____ Date_____

Physician Printed Name_____ City/State_____

Physician Phone #_____ Emergency Phone #_____

OVER

OVER-THE-COUNTER MEDICATIONS - IF NEEDED

If a student requires over-the-counter pain medication or cough drops during the school day they will need to bring in their own medicine to be held in the main office. The medication must be brought in **the original container and labeled with the student's name.** If this form is not returned medication will not be given to the student until one is received. The main office will not administer any other types of medication.

Parent Signature _____ Date _____

Please send questions or forms to Abby Nambo at anambo@st-bede.com