CREIGHTON PREPARATORY SCHOOL
AUTHORIZATION TO ADMINISTER MEDICATION
(Prescription/Allergy/Asthma/Diabetic/Emergency Medication)

Any student who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by designated school personnel when the school has received a written authorization from a physician and from the parent or guardian. No other medication will be administered or provided by school personnel. This includes all non-prescription medication. No written authorization is required for non-prescription medication. A new Student Medication Request Form must be completed:

- If the dose or type of medication is altered,
- If the regime is re-started following the conclusion date of the instructions,
- At the beginning of each new school year.

Medication is to be sent in an original prescription container labeled with the student's name, name of prescribing physician, name of medication and instructions and will be stored in the Dean of Student's Office.

Student _____ **Grade** _____ **Date** _____
Parent _____ **Phone** _____
Health Care Provider _____ **Phone** _____

Medication(s)	Dose	Frequency	Duration	Possible Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional information and/or precautions regarding medication or student's conditions.

_____

Parent/Guardian: I am the parent/guardian of the above student and have lawful custody of said child. I hereby give consent to designated school personnel to administer or assist in administering medication and/or treatment as specified by his health provider. Furthermore, I hereby give consent to the school to receive from or send to the health care provider any information concerning my child's medical condition.

Parent/Guardian Signature_____ **Date** _____

Health Care Provider: I am a licensed physician. I authorize the medication and/or treatment specified above.

Physician Signature_____ **Date** _____

Authorization to Carry and Self-Administer Medication

This student is authorized, with the approval of the Dean of Students, to carry and self-administer while at school the following medications and/or treatments.

- ❑ Asthma Inhaler
- ❑ Epinephrine Injection Kit (Epi-pen)
- ❑ Diabetic Finger Stick Blood Test
- ❑ Insulin Injection

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Student: I certify that I have read and understand the instructions regarding the self-administration of my medication(s). I agree to take these above-described medications in compliance with these instructions.

Student Signature _____ **Date** _____