Form 528A

DIOCESE OF NASHVILLE

REQUEST FOR: ASSISTED SELF-ADMINISTRATION OF MEDICATIONS
[PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS]

Requests for a student to administer his/her own medication during school hours requires that this statement be filed with the school principal. Please respond to every item on this form.* If non-prescription, parent fills out health care provider part.

School _____ School Hours_____ Teacher_____

STUDENT INFORMATION

Student Name _____ Date of Birth_____
Last First Middle

Address _____ Phone _____

Diagnosis (Optional) _____

HEALTH CARE PROVIDER STATEMENT

The Health care provider may be a medical doctor (M.D.), dentist (D.D.S.), physician assistant (P.A.) or registered nurse practitioner/clinician (RN, CS).

To be completed by health care provider: (If non-prescription medication, parent must fill out.)

Name of Drug _____

Date to Start _____ Through _____

Dosage and Times at School _____

Does this medication absolutely need to be administered during school hours? _____ YES _____ NO

If yes, please explain. _____

Special instructions for Storage and Handling _____

_____

Possible Side Effects _____

Health Care Provider Name _____ Phone _____

Address _____

Health Care Provider Signature _____ Date _____
(for prescription medications)

Parent Signature _____ Date _____
(for non-prescription medications)

STUDENT AND PARENT STATEMENTS

I take full responsibility for taking my own medication during school hours as prescribed by my health care provider. Medicine bottles will have the proper pharmacy label. If non-prescription medication, it must be in original container.

Student Signature _____ Date _____

I give consent for my child_____ to take his/her own medicine during the school day assisted by school personnel as necessary. My child is competent to self-administer the medication with assistance. ____ YES ___ NO (check one)

Parent/Guardian Signature _____ Date _____

Phone Number (in case of emergency) _____

*Only completed forms will be honored

Dec. 2000

Note: This form is applicable to chronic, on-going , year round conditions.