Saint Rocco School

Sharing the Love of the Heart of Christ!

MEDICATION CONSENT FORM

931 Atwood Ave.
Johnston, RI 02919
Tel: (401) 944-2993
Fax: (401) 944-3019
www.stroccoschool.org

STUDENT INFORMATION
TO BE FILLED OUT BY PARENT/GUARDIAN

Student Name: _____ DOB: _____ Grade: _____

OVER THE COUNTER MEDICATION
TO BE FILLED OUT BY PARENT/GUARDIAN

Name of Medication: _____

Reason for Medication: _____ Dose: _____ Time to be given: _____

Special instructions: _____

PRESCRIPTION MEDICATION
TO BE FILLED OUT BY A PHYSICIAN or ORDERS CAN BE FAXED BY PHYSICIAN

Diagnosis/Reason for Medication: _____

Name of Medication: _____

Dose: _____ Route: _____ Time to be given: _____

If medicine is to be given PRN, describe indications:

_____

Possible side effects: _____

SPECIAL REQUIREMENTS:
For Inhalers and Epinephrine auto injectors:
_____ Student may self-carry medication _____Student may self-administer medication

For Field Trips:
_____ This medication must accompany child on field trip

PHYSICIAN'S NAME: _____

ADDRESS: _____ PHONE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN ORDERS CAN BE FAXED TO: St. Rocco School @ 401.944.3019 ~ ATTENTION: School Nurse

PARENT AUTHORIZATION

I understand that special permission is required for the use of ANY medication during school hours and that medication may only be given by the school nurse or authorized staff members. I request that my child be given the medication described or to be permitted to self-carry/self-medicate as authorized by me and/or my physician.

Parent/Guardian Signature: _____ Date: _____

CHRIST *is the reason for this school.*
~in our minds, on our lips, and always in our hearts~

CB REVISED 11/20