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 NAME GRADE HOMEROOM

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. I request that my child be given the medication described below or to be permitted to self-carry/self-medicate as authorized by me and my physician.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE

~ THIS SECTION TO BE COMPLETED BY PHYSICIAN ~

Diagnosis/Reason for Medication_____

Name of Medication_____

Dose_____ Route_____ Time to be given_____

If medicine is to be given prn, describe indications:

_____

_____

Restrictions/Important 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 may be omitted on field trip

_____ This student is capable to self-carry/self-administer this medication

(NOTE: Please refer to procedure for students to self-carry/self-administer medication on field trips)

_____ _____

PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S NAME:_____

ADDRESS:_____

PHONE:_____

* PLEASE COMPLETE AND FAX TO: St. Rocco School, @ 401.944.3019 ~ ATTENTION: School Nurse

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