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~

RAO Doc.Nurse /Revised 8/2018