



ARCHDIOCESE OF MIAMI

ARCHBISHOP COLEMAN F. CARROLL HIGH SCHOOL

PRESCRIPTION MEDICATION RELEASE FORM

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

In order for Archbishop Coleman F. Carroll High School personnel to dispense medication to your child, this completed form, along with the medication is to be brought to the school by the parent or student. Prescribed medication/treatment may be administered by designated school personnel. The medication should be brought to the school in the original container appropriately labeled by the pharmacy.

NOTE: Prescribed asthma inhaler may be kept by the student and self-administered if a physician indicates the need in writing and considers the student sufficiently responsible. In addition, the physician should list any precautions to be followed on this form.

Student Name:		ID:	
		Grade:	

Allergies:

Name of Medication:	
Reason for Medication:	
Dosage:	
Form of Medication/Treatment:	<input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhaler <input type="checkbox"/> Injection <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other:
Time Medication is given:	
Restrictions and/or Important Side Effects:	<input type="checkbox"/> None anticipated <input type="checkbox"/> Yes, please describe:
Special Storage Requirements:	<input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Locked storage
Special Administration Procedures:	<input type="checkbox"/> None <input type="checkbox"/> Crush pill <input type="checkbox"/> With Food
Start Medication Date:	
Stop Medication Date:	

I, the undersigned, the parent/guardian of _____, request that the above medication or procedure be administered to my child. I release the school personnel and the school district from liability stemming from adverse reactions and all other adverse effects which may occur because of administering the aforementioned medication.	
Parent/Guardian signature:	Date: