

**Rowland Hall St. Mark's School**  
**Parental Request for Medication Administration by School Personnel**  
**2011-2012**

**PLEASE COMPLETE BOTH Parental Request Form and Medication Administration Form if your child needs medication during school hours.**

**To be completed by parent or guardian and returned by August 12,2011 to become a part of the cumulative health record.**

The undersigned, parent(s) or legal custodian(s) of \_\_\_\_\_, a student at Rowland Hall - St. Mark's School ("School"), hereby request(s) and authorize(s) school personnel to administer a medication known as \_\_\_\_\_ to this child in accordance with the instructions given by the family health practitioner and contained in the attached Prescribing Practitioner's Request to Administer Medication in School.

I (we) certify that this child requires the administration of this medication according to the instructions of the prescribing practitioner as attached.

The undersigned represent(s) that he/she (they) understand that the school employees are medical and non-medical personnel. I (we) hereby request and give my (our) consent to have the medication specified above, administered by the school personnel designated by the School to give my (our) child in accordance with the instructions of the physician as attached. I (we) hereby waive any claim against the School or school personnel arising out of the administration of such medication.

- 1) **The medication is to be brought to School in a container appropriately labeled by the pharmacy, stating the name of the student, the medication, the dose, the pharmacy, and the date of the prescription.**
- 2) The Prescribing Practitioner signing the accompanying request and prescription will review his/her request every school year with any changes in the prescription, or with the renewal of the prescription, whichever is more frequent.
- 3) Pertinent school personnel will be notified that the child is receiving a medication. They will be informed immediately of any changes in the child's condition or changes in schedule of medication.

Parent(s) or Legal Custodian(s):

\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

**Rowland Hall-St. Mark's School**  
**Medication Administration Form 2011-2012**  
**(For Prescription and Over-the-Counter medications, including Tylenol and Ibuprofen)**

(To be completed by prescribing practitioner and returned by August 12, 2011 to become part of the cumulative health record.)

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Allergic to any medication/food, etc? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Name of medication	
Dosage	
Directions/Frequency	
Reason for Medication	
Possible Side Effects	

Name of medication	
Dosage	
Directions/Frequency	
Reason for Medication	
Possible Side Effects	

\_\_\_\_\_  
Physician's Name (Please Print)

\_\_\_\_\_  
Physician Phone Number

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian  
Fax-801.363.5521

\_\_\_\_\_  
Date