OUR LADY *of* ANGELS
CATHOLIC SCHOOL
3644 Rocky River Drive • Cleveland, Ohio 44111 • (216) 251-6841
Fax (216) 252-2383

PARENTAL REQUEST FORM

FOR PRESCRIBED MEDICATIONS

Student Name _____ **Date of Birth** _____

Diagnosis/ Reason for Medication(s):	
Name of Medication(s):	
Medication Form:	☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other:
Special Storage Requirements:	☐ Refrigerate ☐ None ☐ Other:
Start Date:	
End Date:	☐ End of School Year ☐ For Episodic/Emergency Events Only ☐ Other:
Instructions: (Schedule and dosage to be given; please include all medications taken daily.)	**At School:** **Time:**
	At Home: **Time:**
Restrictions/Side Effects:	
Student Responsibility:	**Is the student capable and responsible for self-administering this medication?** ☐ No ☐ Yes (Supervised) ☐ Yes (Unsupervised)
	May student carry this medication? ☐ Yes ☐ No
Additional Information:	**Please indicate if you have provided additional information:** ☐ Yes ☐ No **If so, describe:**

Date: _____ **Signature:** _____ *(Authorized Provider)*

Physician Information:	**Printed Name:**			
	Address:			
	Phone #:		**Emergency #:**	

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____, to receive the above medication at school according to the OLA policy. It is understood that OLA and all of its school personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. It is also understood that by requesting OLA personnel to administer medication to my child that I also allow the prescriber to communicate with the school nurse regarding my child's treatment plan.

Date: _____ **Signature of Parent/Guardian:** _____

Parent/Guardian Information:	**Printed Name:**			
	Address:			
	Home Phone #:		**Work/Emergency #:**	
Reviewed by Nurse:	**Printed Name:**		**Date Reviewed:**	