MEDICATION ADMINISTRATION RECORD

JPII CATHOLIC SCHOOLS

|

| ,

Grad Yr:

Medication Procedure **Dose** **Time**

Special Instructions

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUGUST																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															

*See comments on Back AB=Absent Re=Refused NS=No Show Ho=Holiday

INITIALS	NAME	INITIALS	NAME

MEDICATION ADMINISTRATION RECORD

| Grad Yr:
| ,

JPII CATHOLIC SCHOOLS

This form needs to be completed when it is determined by a physician that medication must be taken during the school hours. Also, it is necessary to fill this out for your child to receive any form of Acetaminophen or Ibuprofen. Please send medication to school labeled with the student's name.

PRESCRIPTION MEDICATIONS

Medication

Dose **Route**

Time / Frequency **Continue Until**

Special Instructions

Major Side Effects

Date

Physician's Signature

Amount of Medication Received by School

Received by **Expiration Date**

NON-PRESCRIPTION MEDICATIONS

Medication

Dose **Route**

Time / Frequency

Date

Parent Signature

Amount of Medication Received by School

Received by **Expiration Date**

SHANLEY / SACRED HEART PARENTS ONLY

My child may take SHANLEY/SACRED HEART supply of Acetaminophen (Tylenol) or Ibuprofen as needed (please check below).

☐ 1 Tablet ☐ 2 Tablets
500 MG Acetaminophen

☐ 1 Tablet ☐ 2 Tablets
200 MG Ibuprofen

Date

Parent Signature

ALLERGIES

DISCLAIMER

I request this medication be given to my child in the manner specified herein. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not necessarily be done by a nurse. I will notify the school immediately if my child’s health status changes or there is a change or cancellation of this medication.

In consideration of this authorization, given at our request, the undersigned agrees to indemnify, defend, and save harmless St. John Paul II Catholic Schools, the individual members, thereof and any officials or employees of St. John Paul II Catholic Schools involved in the administration of medication to the above named student from any claims or liability or damages, including but not limited to costs and reasonable attorney’s fees, caused or claimed to be caused or to result from the administration of the above described medications.

Parent Signature

Date