SCHOOL MEDICATION / PROCEDURE FORM: 2017-2018 SCHOOL YEAR

STUDENT INFORMATION:

______________________	______________________	**Aquinas Middle School**
Student's Name	*Birthdate*	*School*
______________________	______________________	______________________
Medication / Procedure	*Dosage*	*Time / Frequency*
2017-2018	______________________	______________________
School Year or Effective Dates	*Student's Physician*	*Physician's Telephone*

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Reason for Medication / Procedure

NOTE: For prescription medication: Signed Parent Consent and signed Physician's Order required.
For non-Prescription medication: Signed Parent Consent required.

PARENT CONSENT: Complete for EACH MEDICATION / PROCEDURE at school.

I request that this medication / procedure be administered at school.

Medication will be supplied in its original, properly labeled container.

This order is in effect for this school year unless otherwise indicated.

I will notify the school in writing for any changes and obtain a new physician's order.

I authorize school personnel to contact my child's physician if needed.

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

For Asthma inhalers ONLY: May student carry inhaler in school? ☐ **YES** ☐ **NO**

____________	______________________	______________________
Date	*Parent / Guardian Signature*	*Telephone Number*

PHYSICIAN ORDER: Complete for EACH PRESCRIPTON MEDICATION / PROCEDURE at school.

The above medication / procedure is to be administered during the school day in accordance with the above instructions.

Please contact me if the following symptoms occur: ____

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Additional information: ____

____ ______________________

Signature of Physician

AQUINAS MIDDLE SCHOOL
Student Medicine Check Out

Date	*Time*	*Student's Name*	*Medication*	*Dosage*	*Staff Initials*

"This institution is an equal opportunity provider."