**ONLY LIST ONE MEDICATION PER PAGE!**

Also, a new page MUST be completed each time the medication is changed. If you take more than one medication, please make copies of this blank sheet or call us for more!

**ALL MEDICINES MUST BE IN THE ORIGINAL CONTAINER**
~ NO EXCEPTIONS ~

ADMINISTRATION OF MEDICATION BY PERSONNEL

________________________________________ is under my care & should receive:

Printed name of participant

Name of Medication: ________________________ Prescription _____ Non-prescription (over the counter) _____

Dosage/Amount to be given: ________________________ Route/how taken: ________________________

Time to be given: ________________________

Specific Instructions for Administration of medication (ie crushing, given with food): ________________________

Possible Side Effects of Medication:

________________________________________

Expiration of this Request: ________________________

Medical Reason for this medication: ____________________________________________

_____________________________________________________________________

Physician’s signature is required if above medication is a prescribed medication

________________________________________ M.D.

Date

(______) ____________________________

Signature of Physician

Physician’s telephone number

________________________________________

Printed Name of Physician

I hereby request and give my permission to the School Principal and/or assigned delegate to administer the above indicated medication to my son/daughter. Please regard my signature below as my assurance that I release the Roman Catholic Diocese of Cleveland, Bishop of the Roman Catholic Diocese of Cleveland, Secretariat for Catholic Charities Health and Human Services, Disability Services, and the Continuing Adult Education Program Officers or employees from any liability or damages resulting from the consequences of any adverse reactions of our son/daughter taking or failing to take this medication at the times prescribed. I also agree to keep the CAEP informed in writing of any revision in the physician’s prescription. I have had the opportunity to ask any questions. They have been fully answered to my satisfaction.

Parent/Guardian must sign whether above medication is prescription or non-prescription

________________________________________

Printed Name of Parent/Legal Guardian

Date

Signature of Parent/Legal Guardian