Oakland Catholic High School
Request for Self-Administration of Medication (OR)
Administration of Medication during School Hours

Oakland Catholic High School requests that medication be given at home during non-school hours. However, we recognize that some medications will have to be taken during the school day. **ALL MEDICATION TO BE TAKEN AT SCHOOL MUST BE IN THE ORIGINAL CONTAINER. PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL PHARMACY LABELED CONTAINER WITH THE DOSING STRENGTH AND SCHEDULE.**

***** TO BE COMPLETED BY PARENT *****

_____

STUDENT'S NAME **BIRTH DATE** **GRADE**

_____

PHYSICIAN'S NAME **PHONE NUMBER**

I understand fully the directions that have been given to the school by the physician and agree to permit the school to administer the medication as directed or to monitor the self-administration of the medication by my daughter. In consideration of Oakland Catholic's agreement to use good faith efforts to follow the physician's instructions, Oakland Catholic is hereby relieved from liability for any failure to properly administer or to monitor the self-administration of the medication.

I hereby authorize Oakland Catholic to contact the physician (named above) regarding this medication and to release information regarding my daughter (named above) to said physician. I hereby authorize my physician to release information about my daughter and this medication to Oakland Catholic for the purposes of supporting the health of my daughter.

I understand that, in order to protect the limited confidentiality of medical information, my agreement to release information is necessary and that this permission is limited for the purpose and to the person or entity listed above, and will be effective for the present school year. I understand that the disclosed information will no longer be protected by the Health Insurance Portability and Accountability Act and the releasing facility will not be responsible for re-disclosure of the information. I also understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

_____

PARENT/GUARDIAN SIGNATURE **DATE**

***** TO BE COMPLETED BY PHYSICIAN *****

Diagnosis:_____ Length of Treatment:_____
Medication:_____
Dose, Route, and Schedule:_____
P.R.N. (indications and timing):_____
List of Side Effects:_____

Physician's Signature:_____ **Date:** _____