Holy Rosary Catholic School
Cathy Larson, Principal
1043 Lake Avenue, Detroit Lakes, MN 56501 218-847-5306

Medication Request Form

Student Name _____ Grade _____ Birth date _____ Date Today _____

School Medication and Health Care Services are Administered Following These Guidelines:

- Parent signed and dated authorization to administer the medication.
- Medication in the pharmacy labeled container or the manufacturer's labeled container.
- Medication label contains the student name, medication, directions for use and date.
- Annual renewal of authorization and immediate notification in writing of any changes.

Medication/Health Care _____ Dosage _____ Time Given At School _____

Administration Instructions _____

Diagnosis _____

Student is knowledgeable about this medication and may self-administer? Y / N

Licensed Prescriber Signature _____ Date _____

Address _____ Emergency Phone Number _____

Parent Portion

I request this student be given the medication at school and school activities by qualified staff according to Instructions. The student has experienced no serious previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know. I agree to provide safe delivery of medication to and from school, and pick up remaining medication or it will be properly destroyed. All students are responsible to report to the health office for medication unless self-medication is recommended.

Parent/Guardian Signature _____ *Date* _____

Address _____ *Cell Phone* _____ *Home Phone* _____