St. Pius X Catholic School

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Website: www.spxparish.com E-mail: principal@stpiusxcatholic.org

The mission of St. Pius X Catholic School is to provide superior academics in a joyful, safe, welcoming, Catholic, family environment.

Date form received_____

Student_____ Date of Birth_____

Grade_____ Teacher/Classroom_____

To be completed by the physician or authorized prescriber:
Name of Medication_____
Reason for Medication (optional)_____
Form of medication/treatment

□ Tablet/capsule □ Liquid □ Inhaler □ Nebulizer □ Other_____

Instructions (Schedule and dose to be given at school)_____

_____

Start: □ date form received Other date:_____

Stop: □ end of school year Other date/duration:_____

□ For episodic/emergency events only
Restrictions and/or important side effects □ None anticipated
□ Yes, please describe_____

_____

Special storage requirements: □ None □ Refrigerate
Other:_____

This student is both capable and responsible for self-administering this medication:
□ No □ Yes – Supervised □ Yes – Unsupervised

This student may carry this medication: □ No □ Yes
Please indicate if you have provided additional information:
□ On the back of this form □ As an attachment

Date_____ Signature_____

Physician's Name_____

Address_____ Phone Number_____

To be completed by parent/guardian:

I request that_____receive the above medication at school according to standard school policy.
I request that_____be allowed to self-administer the above medication at school according to school policy.

Signature_____ Relationship_____D ate_____