



ST. JOSEPH SCHOOL

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REQUEST FOR SELF ADMINISTRATION/SCHOOL ADMINISTRATION OF MEDICATION 2011-2012

Please complete in black or blue ink

Student's Name _____ Grade _____

Address _____

Home Phone _____

Please check one:

- I, the undersigned, request and authorize the school's staff member to administer and/or store my child's medication(s) listed below.
- I, the undersigned, request and authorize my child to self administer and/or store my child's medication(s) listed below.

I request and authorize release of information between the staff member and the prescribing physician pertinent to the child's condition in cases where the medication is prescribed. I understand that a new request is to be processed should there be any change in medication or physician's orders.

Parent/Legal Guardian's Name (Please Print) _____

Parent/Legal Guardian's Signature _____ Date _____

1. Medication to be Administered _____ Dosage _____

Type of Medication Prescription Over-the-Counter

2. Medication to be Administered _____ Dosage _____

Type of Medication Prescription Over-the-Counter

3. Medication to be Administered _____ Dosage _____

Type of Medication Prescription Over-the-Counter

MEDICATION LOG

DATE	NAME OF MEDICATION	TIME GIVEN	STAFF SIGNATURE