ST. JOSEPH SCHOOL

94-651 FARRINGTON HIGHWAY WAIPAHU, HI 96797
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REQUEST FOR ADMINISTRATION OF MEDICATION
2009-2010

Please complete in black or blue ink

Student's Name_____ **Grade**_____

Address_____

Home Phone_____

I, the undersigned, request and authorize the school's staff member to 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/Guardian's Name (Please Print) _____

Parent/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