Saint Ambrose School
Medication Administration Form

A completed form must be provided to the school nurse before the student may be administered medication.
Please complete one form for each medication and return it to the school clinic.

Student Name	Date of Birth
Grade	School Year

*This section must be completed and signed by the student's parent/guardian.

In consideration of my child being administered medication at my request, on behalf of my child: I hereby assume all risks in the connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, Saint Ambrose School, Saint Ambrose Parish, employees and volunteers from all claims, judgments, liability for any injury or damage due to the designated administration of said medication to my child.

Parent/Guardian Name	Emergency Phone Number
Parent/Guardian Signature	Date

*For non-prescription/over the counter medication: The section below must be completed by parent/guardian. OTC medication does not require physician signature.

*For prescription medication: The section below must be completed and signed by the parent/guardian AND licensed prescriber: must be the signature of a physician or nurse practitioner. As the prescriber I agree to provide in writing a revised statement if any of the following information changes.

Name of medication	
Dosage of medication and time to be administered	
Reason for medication	
Date medication administration begins	Date administration ends (if known)
Possible adverse reaction to the student to which it is prescribed (to be reported to the prescriber):	
Special Instructions:	
Prescriber Name (print)	Prescriber Phone Number
Prescriber Signature	Date