

St. Vincent de Paul School

14330 Eagle Run Drive
Omaha, NE. 68164
402.492.2111 *phone*
402.496.9933 *fax*

IMPORTANT HEALTH NEWS

RE: Medication Authorization

This form MUST accompany all medication sent to the school

Dear Parent/Guardian,

Student _____ Grade _____ Age _____

Directions:

IF the medication is a prescription, the doctor completes part I AND the parent completes part II

IF the medication is available over-the-counter, part I is left blank; the parent completes part II

I. PHYSICIAN DIRECTIONS - completed by the doctor

Name of medication to be given _____

Dosage _____ Route _____ Time _____

Starting Date _____ Ending Date _____

Purpose of Medication _____

Possible side effects/observations to note _____

Physician requests comments from school? Yes _____ No _____

This medication may be safely given by an unlicensed individual who has demonstrated competency in medication provision.

Physician Signature _____ Phone _____ Date _____

II. PARENT/GUARDIAN DIRECTIONS--COMPLETE SECTION A AND ANY OTHER SECTION THAT APPLIES.

A. Name of Medication to be given _____

Starting Date _____ Ending Date _____

I request the student named above receive this prescribed medication while in school and school related activities. I understand it is my responsibility to furnish the medication in the original container or a prescription bottle appropriately labeled by the pharmacy or physician stating the name of the student, the medication, dosage, and instructions. I accept the responsibility of monitoring the action and side effects of the medication and ask that I be notified if the following occurs:_____. I find the following unlicensed individuals competent to provide the medication: Barb Marchese, Principal; Diane Warneke and Paula Elgert, Asst-Principals; Nancy Morey, Secretary; Carrie Meiers, Receptionist; Michele Madrigal, Admin Assistant.

Parent/Guardian Signature _____ Date _____

OVER

B. Complete this section in addition to Section A ONLY IF medication is as needed or over the counter medication:

Name of Medication: _____

Dose of Medication: _____

Medication should be provided when: _____

Additional instructions: _____

I find the following unlicensed individuals competent to provide the medication: Barb Marchese, Principal; Diane Warneke and Paula Elgert, Asst-Principals; Nancy Morey, Secretary; Carrie Meiers Receptionist; Michele Madrigal, Admin Assistant.

Parent/Guardian Signature _____ Date _____

C. Complete this section in addition to Section A ONLY IF medication is given by a route OTHER THAN oral, inhalation, topical. or instillation:

Written procedure (may be attached): _____

I find the following unlicensed individuals competent to provide the medication: Barb Marchese, Principal; Diane Warneke and Paula Elgert, Asst-Principals; Nancy Morey, Secretary; Carrie Meiers, Receptionist; Michele Madrigal, Admin Assistant.

Parent/Guardian Signature _____ Date _____

D. Complete this section in addition to Section A ONLY IF participation in monitoring is necessary:

I request that the following observations be made and reported in the time lines stated (may be attached): _____

I find the following unlicensed individuals competent to assist in monitoring the medication: Barb Marchese, Principal; Diane Warneke and Paula Elgert, Asst-Principals; Nancy Morey, Secretary; Carrie Meiers, Receptionist; Michele Madrigal, Admin Assistant.

Parent/Guardian Signature _____ Date _____

If you have any questions please call me at 402-452-2267.

Sincerely,

Bridget Yordt, RN
SVdP School Nurse

Revised 3/6/14