St. Vincent de Paul School
14330 Eagle Run Drive
Omaha, NE. 68164
402.492.2111 *phone*
402.496.9933 *fax*

IMPORTANT HEALTH NEWS

RE: Medicaton Authorizaton

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 Lisa Nelson, 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 Lisa Nelson, 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 Lisa Nelson, 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,

Nicole Pisarik, RN
SVdP School Nurse