

**2011/2012**  
**ST. MARK CATHOLIC SCHOOL**  
15724 Montrose Avenue • Cleveland, OH 44111  
TEL: 216-521-4115 FAX: 216-221-8664  
**PARENTAL REQUEST FORM FOR PRESCRIBED MEDICATION**

\_\_\_\_\_  
Student's Name Homeroom Date of Birth

**I. TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER**

Diagnosis / Reason for Medication \_\_\_\_\_

Name of Medication \_\_\_\_\_

Medication Form:  Tablet/Capsule  Liquid  Inhaler

Injection  Other

Special Storage Requirements:  Refrigerate  None  Other

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

\_\_\_\_\_ For Episodic / Emergency events only

Instructions (schedule and dosage to be given):

\_\_\_\_\_  
Restrictions / Side Effects:

\_\_\_\_\_  
Adverse reactions that should be reported to physician:

\_\_\_\_\_  
Procedure to follow in event medication does not produce expected relief:

\_\_\_\_\_  
If prescribing an epipen or rescue inhaler, is student capable and responsible  
to self-administering this medication:  Yes  No

May student carry the epipen or rescue inhaler?  Yes  No

\_\_\_\_\_  
Authorized Prescriber (Signature)

\_\_\_\_\_  
Date

PHYSICIAN'S PRINTED NAME: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Emergency No.: \_\_\_\_\_

**II. TO BE COMPLETED BY PARENT / GUARDIAN**

It is not possible for the above-specified medication to be taken at home under the supervision of a parent and it is, therefore, necessary that the specified medication be administered during school hours. This medication can be safely administered by non-medical personnel. I give permission for my child, \_\_\_\_\_, to receive the above medication at St. Mark Catholic School according to St. Mark Catholic School policy. In consideration of my child being administered the above medication at my request, on behalf of my child, my spouse, and myself, I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, St. Mark Catholic School, employees, and volunteers from all claims, judgments, liability for any injury or damage due to the designated administration of said medication to my son / daughter.

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Telephone/cell No. \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Work/Emergency No.: \_\_\_\_\_