Bishop Eustace Preparatory School

Office of the Nurse

MEDICATION CONSENT FORM 2014-15

Attention: We are required to collect a "Medication Consent" form Annually from EVERY student. It must be appropriately completed and signed by Parent/Guardian AND all consents must be co-signed by the student's Health Care Provider. All signatures MUST BE LEGIBLE and Verifiable.

Parents,

Students often complain of headache, muscle aches, colds, menstrual cramps etc. during school hours, and request Aspirin or Tylenol. Often after the Nurse assesses this complaint, relieves it as requested and provides a few minutes rest, students are able to comfortably resume their course of studies. When students are unable to receive medication from an appropriate source, they often turn to friends for whatever medicinal help they have available. We wish to discourage that practice here at Bishop Eustace.

Please complete and sign this form where indicated and have it co-signed by your family doctor. This permission or denial will remain in effect for **this school year (only)**, unless we are subsequently notified by you or your physician to rescind or change it. Parents/guardians acknowledge that the school and its employees or agents shall incur no liability as a result of any injury arising from the administration or the failure to administer these medications and shall, therefore, indemnify and hold harmless the school and its employees or agents against any claims arising out of the administration of medication or the failure to administer the medications. Your signature also indicates that you have read and agree to comply with the medication policy published in the Student Handbook, and understand the consequences if your child fails to do so. If you have further questions, please call the Nurse's Office. 856-662-2160 ext.298.

I request that my child _____, Class of _____ be given / not be given
(Please print student's name) **(circle one)**

Acetaminophen for usual the reasons listed above.
(generic Tylenol)

My child also takes_____ on a regular / occasional basis for
(Name of medication(s) **(circle one)**

reason(s): _____.

He/she may need to take this at school. **If this med is to be self-administered,** a **"Self–Medication Form" must also be submitted.**

X _____ _____ _____
(parent/guardian) (date) (relationship to student)

***** In the absence of any other symptoms, I am aware of no medical reason to preclude this child's receiving the Over-the-Counter Medications requested by his/her parent/guardian for conditions listed.**

X _____ __MD __DO or __NP __ PA (assoc with DR. _____
Physician / Provider's Signature

Date _____ Phone _____

_____
Please PRINT provider name or stamp with Name included

Route 70, Pennsauken, NJ 08109 * Nurse's Phone (856) 662-2160 ext.298 * Nurse's Fax (856) 662-5674