

St. Columbkille School

224 E. 5th Street
Papillion, NE 68046
Phone: (402) 339-8706
FAX: (402) 592-4147

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION 2010-2011

All medication must be brought in the prescription container with the original pharmacy label. Prescriptions must be labeled with the student's name, date, name of medication, medication dose, and time to be given. Medication WILL NOT be administered if it is not in the original container. Please ask your pharmacist to provide two labeled bottles--one for home and one for school.

Please arrange medication administration outside of school hours if at all possible.

Student's name _____ Grade _____

For the child named above, I request and grant permission to school personnel (medication will not necessarily be administered by the school nurse) to administer the above medication as ordered by the physician. I understand that it is my responsibility to furnish the medication and any medical equipment needed to administer the medication.

Signature of parent _____ Date _____

Daytime telephone number _____

PHYSICIAN DIRECTIONS FOR USE OF ASTHMA MEDICATION

Name of medication to be given _____ Physician Action Plan Attached Yes No

Starting date _____ Termination date _____

1. Nebulizer Dosage: 1 premixed vial other _____
2. Inhaler Dosage: 1 puff 2 puffs other _____
3. To be administered: q 2-4h q 4-6h prior to exercise prn other _____
 if no improvement medication may be repeated after 15 minutes

Possible side effects:

Signature of Prescribing Physician

Date

Address of Physician's Office

Telephone Number

***At the close of the school year, a parent or legal guardian must claim any unused medication in the school office. Medication that remains unclaimed after June 1, 2011, will be discarded.**