Mater Dei Academy 2026-2027

Health Services

MEDICATION PERMISSION AND PHYSICIAN INSTRUCTION

Student Name:_____ Date of Birth:_____
Last name First Name Month Day Year

Address:_____
House number/Street Apt. # City Zip

School: Mater Dei Academy Grade_____ Teacher:_____
Teacher's Name

PARENT/GUARDIAN PERMISSION (to be completed by parent/guardian)

I give permission to the school nurse and to those persons she has inserviced to administer the medication(s) listed below. I give permission to the school nurse to communicate as warranted with the undersigned physician regarding my child's medication. I understand that the school district and its employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the pupil.

Printed Name:_____ Home Phone:(_____)_____
Parent/Guardian printed name

Signature:_____ Work Phone: (_____)_____
Signature of Parent/Guardian

Date of Signature:_____

PHYSICIAN'S ORDERS (to be completed by student's physician)

1. **Medication:**_____

   Dose:_____ Frequency:_____

   Diagnosis:_____

   Side Effects:_____

   Medical protocol may require an adjustment of medication. Verbal orders for increase or decrease in increments of _____ are inherent in this order only.

2. **Medication:**_____

   Dose:_____ Frequency:_____

   Diagnosis:_____

   Side Effects:_____

   Medical protocol may require an adjustment of medication. Verbal orders for increase or decrease in increments of _____ are inherent in this order only.

I understand that the above medications require annual review and authorization by me. Any changes in medication or dose prior to this review require written authorization.

Signature:_____ Date of signature_____
Signature of Physician Month Day Year

Physician's Printed Name:_____

Office Address_____
Street Address Suite # (if necessary) City Zip

Office Phone: (_____)_____ Fax Number: (_____)_____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL HEALTH OFFICE

MATER DEI
Academy
Moral Values • Discovery • Achievement

Dear Parents/Guardians:

According to the directives from the Ohio Legislature, no child can receive medication during the school day without consent from the **parent and physician**. Medication will be kept in the clinic and administered by our staff. The clinic will provide you with the proper forms to be completed. These forms must be completed for prescription **and** over the counter medication (i.e. Tylenol, Advil, cough syrup, eye drops, ointments, creams).

A legal guardian must bring medications and signed forms to the clinic to be checked in. No medicines should be given to students to bring in. All medicines must be in the original containers.

For children who receive emergency medications (inhalers, epi-pens, glucose tablets), your child may carry and administer that emergency medication **if they have a *self-carry/self-administration order*** on file in the clinic.

No medication can be given without these forms on file in the clinic. No exceptions can be made.

Thank you.

Mrs. Sonya McKeown
Clinic

Phone: 440-585-0800 ext. 121
Fax: 440-569-1438
Email: smckeown@materdeiacademy.us