



Diocese of Steubenville
Office of Christian Formation and Schools

DISPENSATION OF MEDICATION, Form M-3

SECTION A – To be completed by the parent

Student's name/birthdate

Name of School/Homeroom Teacher

Address

Telephone number (For Emergency contact)

We (I) the undersigned, who are the parent(s) guardian(s) of the above-mentioned child, request that the health care service, outlined below and prescribed by the physician, be provided to our child. We(I) authorize the school to appoint a qualified, designated person(s) to perform the prescribed treatment as directed by the physician. We (I) agree to notify the school personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician.

Parent's/guardian's signature

Date

Emergency Phone contact

SECTION B – To be completed by the physician

Name of Physician

Telephone number

Office address

Name of the treatment/medication: _____

Specific/special instructions for administration: _____

Student may self-medicate: _____ Yes _____ No

Beginning date: _____ Ending date: _____

Adverse reactions that should be reported to the physician: _____

Special storage instructions: _____

Physician's signature: _____

Date

**MEDICATION MUST BE IN THE ORIGINAL CONTAINER IN WHICH IT WAS DISPENSED
AND LIMITED TO ONLY THAT AMOUNT WHICH IS NEEDED!!**