2025-2026 BCHS Permission for Prescription Medication

Please have the PHYSICIAN'S OFFICE complete this form for all prescription medications, including epi-pen and inhalers.

I. PHYSICIAN: _____ a patient under my care who at the present time is being prescribed medication
(name of patient)
that must be administered during the school day. The following is a description of the medical order:

Name of Prescription Medication: _____

Purpose: _____

Dosage and Directions: _____

DR._____
(Physician's Signature)

II. PARENT:

I hereby request that an authorized representative of Bishop Chatard High School make available the above described prescription to my son/daughter listed above, in accordance with the physician's written order. I understand that I may withdraw this consent at any time by submitting a written request to the principal's office. Furthermore, I understand this consent is valid for only one year.

Parent/Guardian Signature: _____ Date: _____

NOTE: THIS PERMISSION IS ONLY VALID FOR ONE SCHOOL YEAR. MEDICATION MUST BE IN THE ORIGINAL CONTAINER. MEDICATION MUST BE KEPT IN THE NURSE'S OFFICE. MEDICATION WILL BE TAKEN BY THE STUDENTS THEMSELVES UNDER THE SUPERVISION OF A SCHOOL REPRESENTATIVE.

Parent Responsibility for use of Inhaler at School

My child/youth has been made aware by me (parent/guardian) that his/her inhaler is for his/her use only and may not be shared with others.

My child/youth has been made aware by me (parent/guardian) that he/she must notify the school nurse or other staff member immediately following each use of an inhaler in case follow-up response in needed.

Bishop Chatard High School is not responsible for ensuring that all the above medication(s) is taken and is relieved of responsibility for the benefits or consequences of the child/youth using or not using the medication described above.

Parent/Guardian Signature: _____ Date: _____

****Please include any additional notes about your child for the school nurse below****

ADDITIONAL NOTES:

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