# MEDICATION LOG

Name of Student ____________________________  Section/Grade/Homeroom ____________________________

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>STRENGTH</th>
<th>DOSAGE</th>
<th>TIME TO BE GIVEN</th>
<th>DURATION OF ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>DOSAGE</td>
<td>ADMINISTERED BY: (Sign)</td>
<td>DATE</td>
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</tbody>
</table>

Policy
Adopted: May 30, 1996

___________________________
Bishop of Harrisburg
# Pupil Accident Report

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>NAME OF PUPIL</th>
<th>GRADE</th>
<th>Nature of Illness or Injury</th>
<th>Where and How Accident Occurred</th>
<th>Care Given and By Whom</th>
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Bishop of Harrisburg
Emergency Medical Authorization (Please print)

Student's Name ____________________________ S.S. # ____________ Birth Date

Address ______________________________________ Home Phone

Mother's or Guardian's Name
Where Employed ____________________________ Telephone ____________ Ext.
Father's or Guardian's Name
Where Employed ____________________________ Telephone ____________ Ext.

IF ABOVE PARENTS/GUARDIANS CANNOT BE REACHED, PLEASE CALL:

(A) First Contact's Name ____________________________ Relationship
    Address ____________________________ Work phone # ____________ Home phone #

(B) Second Contact's Name ____________________________ Relationship
    Address ____________________________ Work phone # ____________ Home phone #

In case of accident or serious illness, I request the school to contact me or my designate. If this cannot be done, I authorize the school to call the physician or dentist listed on this card and to follow his/her instructions. If the physician or dentist named cannot be reached, the school may seek medical services that seem necessary. I realize the school does not assume responsibility for the payment of medical expenses.

Signature of Parent or Guardian ____________________________ Date

(OVER)

In the event emergency treatment is needed, I give the hospital, its authorized personnel and/or physician permission to treat my son/daughter as necessary.

Signed ____________________________ Date

Medical problems __________________________________________ Taking Medication Yes ___ No

If yes, Type ____________________________ Reason ____________________________ (Medication will be administered at school only according to current school policies.)

Physician/clinic ____________________________ Phone

Dentist ____________________________ Hospital Preference ____________________________ Phone

OR

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take no action or to:

Signature of Parent or Guardian ____________________________ Date

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Bishop of Harrisburg