"The Shining Star: Enlightening Minds, Reflecting Faith"

Parental Consent for Medication Administration

Date:___________

Student:___________________________________ **Grade:_______________**

My child is to receive ___________________________ medication according to the physician's

directions given for _____________________________. Treatment will last for _________ days.

My child has _________________________________ drug allergies.

I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication. I understand and acknowledge that any medication to my child during school will more than likely not be administered by a registered nurse or other medial professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.

Parent/Guardian Signature:____

Physician Consent for Medication Administration

Date:___________ **Student:_________________________**

Medication:___________________________

Dose:______________________ **Time Interval:_________________________**

Diagnosis/reason for treatment:____

Side effects to look for:____

Restrictions:____

Doctor Signature:____

Phone Number:__________________