

***Parental Consent for Medication Administration to the Child***

Date: \_\_\_\_\_

School: \_\_\_\_\_

Student: \_\_\_\_\_

Grade: \_\_\_\_\_

My child is to receive \_\_\_\_\_ medication according to the physician's directions given for \_\_\_\_\_.

This treatment will last \_\_\_\_\_.

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 administered to my child during school will more than likely not be administered by a registered nurse or other medical 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 to my child.

Signature: \_\_\_\_\_

-----  
***Physician Consent for Medication Administration***

Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Time Interval: \_\_\_\_\_

Diagnosis or reason for treatment: \_\_\_\_\_

Side Effects to look for: \_\_\_\_\_  
\_\_\_\_\_

Restrictors: \_\_\_\_\_

Signature: \_\_\_\_\_