

PARENT'S REQUEST FOR THE ADMINISTRATION
OF MEDICATION BY SCHOOL PERSONNEL

I HEREBY AUTHORIZE, REQUEST AND GIVE MY CONSENT TO THE PRINCIPAL, OR HIS/HER DELEGATE (SCHOOL NURSE OR OTHER RESPONSIBLE PERSON) TO STORE, SUPERVISE AND/OR ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD. IT IS IMPOSSIBLE TO ARRANGE FOR THIS MEDICATION TO BE TAKEN AT HOME, THEREFORE IT MUST BE ADMINISTERED DURING THE SCHOOL HOURS.

Name of Student: _____ Homeroom _____

Name of medication: _____

(Prescription medication **must** be in original container)

Dosage: _____ Expiration Date: _____

Route of administration: _____

Time/s of day to be administered: _____

It is the student's responsibility to come to the clinic at the proper time.

Date to begin: _____

Date to complete: _____

I RELEASE THE DIOCESE OF ST. PETERSBURG AND _____ SCHOOL AND ANY AND ALL EMPLOYEES AND STAFF, FROM ANY LIABILITY OR DAMAGES RESULTING FROM THE CONSEQUENCES OF ALLOWING SCHOOL PERSONNEL TO ADMINISTER THE ABOVE MEDICATION, OR ANY ADVERSE REACTIONS OF MY CHILD TAKIING OR FAILING TO TAKE THIS MEDICATION AT THE TIME PRESCRIBED. I UNDERSTAND THAT I HAVE THE PRIMARY RESPONSIBILITY FOR ADMINISTRATION OF MEDICATION, BUT IN MY ABSENCE, I CONSENT AND AUTHORIZE THE SCHOOL TO ASSIST ME WITH THIS OBLIGATION. I FURTHER AGREE TO KEEP THE SCHOOL INFORMED IN WRITING OF ANY REVISIONS TO THE PHYSICIAN'S PRESCRIPTION AND DIRECTION.

Signature of Parent/Guardian

Date

Rel 7/90