

## PARENTAL/PHYSICIAN PERMISSION TO ADMINISTER MEDICATION

This form must be completed by the prescribing physician and parent(s) prior to administration of medication by St. Pius X personnel. This form is intended for all non-prescription medication (over-the-counter) and prescription medication. All medication must be in the original, labeled container in which it was dispensed. Over the counter medication needs to be in its original labeled package/bottle.

STUDENT'S NAME: \_\_\_\_\_

GRADE: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_ ROUTE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

REASON FOR TAKING MEDICATION: \_\_\_\_\_

\_\_\_\_\_

SPECIAL INSTRUCTIONS: \_\_\_\_\_

\_\_\_\_\_

DATE MEDICATION IS TO START: \_\_\_\_\_

DATE MEDICATION IS TO END: \_\_\_\_\_

POSSIBLE ADVERSE REACTIONS OR SIDE EFFECTS: \_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_ PHYSICIANS SIGNATURE: \_\_\_\_\_

PHYSICIANS PHONE #: \_\_\_\_\_

### FOR THE PARENT:

I hereby request and give the school personnel the right to oversee administering the prescribed medication. I authorize the school personnel to administer the medication or procedure as instructed by the physician and agree:

- To personally deliver the medication to the school
- To notify the school if the physician is changed
- To notify the school if the medication, the dosage or procedure is changed or discontinued

In consideration from the overseeing and administration of medication for my child, I hereby release, discharge and indemnify the Diocese of Toledo Catholic/Private Schools, St. Pius X, and the school personnel in the overseeing and administration of medication herein described from all claims, demands, actions, judgments, and executions which may arise from the overseeing or dispensing of the medication. The undersigned have read this form and understand all of its terms.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date