

Parental Consent for Medication Administration to their Child

Date: _____

School: Saint Ferdinand Catholic 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 medication to my child.

Signature: _____

Relationship to student: _____

Physician Contact Information: _____

Physician Consent for Medication Administration

Date: _____ Name of Student: _____

Medication: _____ Dose: _____

Time Interval: _____

Diagnosis or reason for treatment: _____

Side Effects to look for: _____

Restrictions: _____

Signature of Physician

Phone Number