Parental Request for Medication Administration at School

I request that my child, ____ Grade: ________

Teacher: ____

Receive the following medication ____

For: ____

Prescription # / Pharmacy if applicable: ____

Prescribing Physician: ____

Dosage: ____

How Often: ____

Time to be Administered: ____

Date to Begin: ___________________________ Date to End: ___________________________

Allergies: ____

The medication should be delivered to the school's office. It should be in a container properly labeled from the pharmacy with the student's name, physician's name, name of medication, dosage, and frequency, and date of the original prescription.

I hereby authorize St. John the Baptist Catholic School's principal, school nurse, nurse's assistant, assistant principal, or secretary to assist my child in taking oral medication. I agree that I will not hold liable any member of the school staff or an individual of official capacity who is directed by me (the parent) and the school administrator to assist my child in taking said oral medication.

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Signature of Parent or Legal Guardian Date