MEDICATION PERMISSION FORM

Student's Name: ________________________________ Date: _______________

Grade/Class Student is in: ____________________

MEDICATION TO BE GIVEN, AMOUNT, ROUTE OF ADMINISTRATION, AND TIME TO BE ADMINISTERED:

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WILL THERE BE ANY RESTRICTIONS FOR SCHOOL ACTIVITY WHILE STUDENT IS ON THIS MEDICATION? IF YES, HOW LONG WILL RESTRICTIONS EXIST?

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I understand that this medication will be given by the school principal or the principal's designee. I further release the school and its personnel from any liability resulting from any untoward effects that this medication may cause when dispensed at school. I understand that if I do not agree to and sign the Medication Policy, that the medication will not be administered at school.

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Parent/Legal Guardian Signature

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Date

I agree to ensure administration of the above medication according to diocesan policy.

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Principal