Physician and Parental Consent for Medication Administration

St. Pius X High School Festus, MO

APPENDIX 1 4.1

DATE:_____

NAME OF STUDENT:_____ GRADE:_____

DRUG ALLERGIES:_____

This section must be completed by physician.

MEDICATION	*DOSE*	*FREQUENCY*	*REASON*	*SIDE EFFECTS TO LOOK FOR*	*RESTRICTIONS*

Physician Signature:_____phone#_____

I give my permission for these medications to be administered to my child at school. The school has my permission to call the physician with any questions regarding these medications.

I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a medical professional. I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representatives, from any liability that may arise from administering medication to my child.

Parent/Guardian Signature(s):_____phone #_____

Must have a Physician's orders and Signature for all prescription and over-the- counter medications.