School Year: _____ **School/Center:** _____

Address: _____

_____

Phone & Fax: _____

Consent for Medication

(Consent is for 12 months only) ***(Renew at beginning of the school year)***

Name of Child: _____ **DOB** _____

Drug Allergies: _____

Name of Medication: _____ **Dose:** _____ **Time:** _____

Diagnosis/Reason for Medication(s) (prescription and over-the counter):

_____

Name of Medication: _____ **Dose:** _____ **Time:** _____

Diagnosis/Reason for Medication(s) (prescription and over-the counter):

_____

Name of Medication: _____ **Dose:** _____ **Time:** _____

Diagnosis/Reason for Medication(s) (prescription and over-the counter):

_____

SPECIAL INSTRUCTIONS/COMMENTS:

_____

_____

PLEASE NOTE: MEDICATION CANNOT BE DISPENSED FROM UNLABELED CONTAINERS. ALL PRESCRIBED MEDICATION MUST BE SENT IN A LABELED PRESCRIPTION CONTAINER FROM THE PHARMACY. ALL OVER-THE-COUNTER MEDICATION MUST BE PROVIDED IN THE ORIGINAL MANUFACTURER'S CONTAINER AND LABELED WITH THE STUDENT/CHILD'S NAME AND DOSAGE. EXPIRED MEDICATIONS CANNOT BE ADMINISTERED.

STUDENTS/CHILDREN ARE NOT ALLOWED TO CARRY MEDICATIONS (PRESCRIPTIVE OR OVER-THE-COUNTER) WITH THEM. ALL MEDICATIONS ARE TO BE KEPT WITH SCHOOL/CENTER STAFF MEMBERS. STUDENTS/CHILDREN WITH PROPER AUTHORIZATION MAY BE ALLOWED TO CARRY AND SELF-ADMINISTER ASTHMA OR OTHER MEDICATIONS FOR LIFE THREATENING CONDITIONS. (Contact the school/center staff for more information).

PARENT/GUARDIAN PERMISSION: I hereby give my permission for designated school/center personnel to administer the medication described above as directed by the licensed health care provider. I accept responsibility for immediately notifying the staff of any change in these instructions. Further, I indemnify and hold harmless this school/center, parish, the Kansas City-St. Joseph Diocese and its employees or agents against any claim from the use of this/these medications.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**