Santo Niño Regional Catholic School

PERMISSION FORM FOR ADMINISTERING MEDICATION IN SCHOOL

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

Address: _____ Home Phone: _____

Parent/Guardian's Name: _____ Work Phone: _____

TO BE COMPLETED BY THE PHYSICIAN

Medical condition necessitating medication:

Name of Medication(s): Possible Side Effects:

_____ _____

_____ _____

_____ _____

Directions for medication(s):

Option for medication administration (check one):

_____Self-administration (Inhaler only) as instructed by ___ physician ___ parent
_____Supervised administration (administered by school nurse according to physician's instruction)

_____

Physician's Signature Phone Number Date

PARENT/GUARDIAN STATEMENT:

I/We, the parent(s) of _____ (Student's Name) hereby request that this medication be given to my/our child according to the physician's instructions. I grant permission for Santo Niño Regional Catholic School to exchange information regarding medication with my child's doctor.

I/We agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician's statement if there is ANY change in the medication, dosage, administration time, administration route, or special instructions regarding the medication.

Furthermore, I agree to indemnify Santo Niño Regional Catholic School and its agents and employees from any claims, suits, judgments, or costs of defense (including attorney's fees) arising from any such actions or inactions.

Parent/Guardian's Signature:_____ Date:_____

School Nurse's Signature: _____ Date:_____