

ST. MARY'S CATHEDRAL SCHOOL – AMARILLO, TX
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:

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

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.

Parent/Legal Guardian Signature

Date

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

_____, Principal