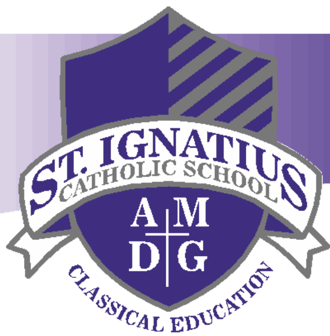

St. Ignatius Catholic School

Administration of Medication Consent

Use one form for each medication. Please print.

Student Name: ____ Date of Birth: ______________

Parent/Guardian Name: ____

Grade______________ Homeroom Teacher: ____

Medication Name: ______________________________________ Prescribed*: ☐ Non-Prescribed: ☐

Dosage (in mg, ml, etc.): __________ How Given: ____________ Time to be Given: _________________

Starting Date: ___________________________ Termination Date: _______________________________

Reason for Medication:

____

____

If "as necessary," conditions under which medications should be given:

____

Precautions, possible unexpected reactions, and/or interventions:

____

____

PRESCRIPTION MEDICATION - Prescribing Physician Name: __________________________________

Prescribing Physician Phone: ______________________ Name of Clinic: __________________________

I hereby give my permission to school personnel to give this medication to my child according to the directions stated above and to contact the child's physician if necessary.
I further agree to hold St. Ignatius Catholic School System and the person dispensing the medication harmless in any and all claims arising from the administration of this medication at school.

I agree to notify school in writing when any change in the above order is necessary.

Parent/Guardian Signature: ___________________________________ Date: _______________________

Home Phone: __________________________ Cell Phone: _______________________________________

A physician written, signed statement and a pharmacy labeled container with accurate dosage and administration instruction must be supplied by the parent/guardian.

I agree to allow my child to transport the medication container (filled or empty) to and from school for the purchase of maintaining medication needed at school for administration. Yes ☐ No ☐

Rev. 08/2022