St. Ignatius Catholic School

Administration of Medication Consent

Use one form for each medication. PLEASE PRINT

Student Name: _____ Date of Birth: _____

Parents Name: _____

Grade_____ 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.

Parents 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 ☐