ST. JOAN OF ARC SCHOOL

PARENTS' PERMISSION AND RELEASE FOR SCHOOL PERSONNEL TO OVERSEE ADMINISTERING MEDICATION AND RELEASE FROM LIABILITY

I hereby request and give the Principal or other appropriate school personnel the right to oversee administering prescribed medication noted below. I authorize the school personnel to administer medication or procedure as instructed by the physician and agree:

1. to deliver the medication to the school
2. to notify the school if physician is changed
3. to notify the school if medication, the dosage or procedure, is changed or to be eliminated.

Name of student _____

Grade/Room _____ Date of request _____

Name of drug or medication: _____

Dosage: _____ at _____
(time/s)

Reason for taking this medication: _____

_____

Date medication to start: _____

Date medication to end: _____

Other medication or drugs child is taking: _____

_____

In consideration from the overseeing and administration of medication for this child, I hereby release, discharge and indemnify the Diocese of Toledo, the Toledo Catholic/Private Schools, this school, the Principal of the responsible school and his/her designee and any other persons involved in the overseeing and administration of medication or drugs herein described, from all claims, demands, actions, judgements, and executions which may arise from the overseeing or administration of the medication. The undersigned have read this form and understand all of its terms.

Date: _____ _____
Parent/Legal Guardian

_____
Parent/Legal Guardian

* If parents share custody under a court agreement, both must sign.

FAX (419) 866-4107

ST. JOAN OF ARC SCHOOL

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____, _____ enrolled
name of student address

in _____ at St. Joan of Arc School is under my care and should receive:
Grade/Room

_____
name of medication and dosage

at the following times or intervals: _____,

beginning _____ until _____.
date date

Reason for receiving this medication: _____

_____

Specific instructions for administration and storage: _____

_____

Possible adverse reactions or side effects to watch for and report:

_____

_____

Expiration date of this request: _____

Other medication child is presently taking: _____

_____

I understand that the school will not independently verify the above instructions.

Date: _____ _____
Physician's Signature

_____
Physician's Telephone Number