Saint Mary
OF THE IMMACULATE CONCEPTION SCHOOL

SCHOOL HEALTH SERVICES 2017-2018 SCHOOL YEAR

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

I hereby request, authorize and give my permission to the principal or his designee (e.g. school nurse or responsible person) to administer the following medication(s) to my child:

Name of Student: _____ **Date of Birth:** _____

Student Address: _____ **Grade:** _____

City & ZipCode: _____ **Phone:** _____

is under my care and should receive the following medication as indicated below:

Name of Medication: _____ **Dosage/Route:** _____

Frequency: _____

Beginning Date of this Request: _____ **Ending Date of this Request:** _____

Specific instructions for Administration: _____

_____

Reaction(s) and/or possible side-effects to be reported to physician: _____

_____

It is not possible for the above specified medication to be taken at home by my son/daughter under the supervision of a parent/guardian and it is, therefore, necessary that the specified medication be administered during school hours.

In consideration of my child being administered the above specified medication at my request, on behalf of my child, my spouse, and myself, I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, Saint Mary of the Immaculate Conception School, Saint Mary of the Immaculate Conception Parish, all employees and volunteers from all claims, judgments, liability for any injury or damage due to the designated administration of said medication to my son/daughter.

Physician's Name: _____ **Phone:** _____

Physician's Signature: _____ **Date:** _____