SAINT CLEMENT SCHOOL
PARENT/GUARDIAN MEDICATION CONSENT FORM
(Please type or print)

Full name of child to be medicated _____

Name of drug and dosage _____

Hour(s) medication to be given _____ Number of days _____

Name of Student's Physician _____ Phone _____

Reason for medication _____(if applicable)

Name of person(s) authorized to give medication during school hours: _____

_____(to be filled out by school principal or program administrator other designee)

My child has permission to self-administer the medication, but I request school staff monitor or assist my child when

he/she self administers medication on the following basis: _____

_____(indicate if not applicable)

I hereby give permission to the above named person(s) to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician, if necessary. I agree to hold the school, its employees an agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication at school. I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

Signature of Parent/Legal Guardian: _____ Date: _____

Address: _____

NOTE:

Before a prescription drug(s) or medications(s) will be administered by the school or an agent thereof, a PHYSICIAN ORDER FOR MEDICATION ADMINISTRATION shall be completed and returned to the school principal. This completed form shall be accompanied by the PARENT/GUARDIAN MEDICATION CONSENT FORM. This form (Parent/Guardian Medication Consent) must also be completed for the administration of non-prescription (over-the-counter) drug(s) or medication(s) which do not require the Physician Order.

School Principal: _____ Date: _____

FOR SCHOOL PERSONNEL

NAME OF STUDENT: _____

MEDICATION: _____

DATE	TIME	SIGNATURE