
REQUIRED FOR PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

Please administer the following medication(s) to my child in the manner(s) specified by the named physician. I understand that the medication(s) will be administered by a person who is not medically trained. I agree to save, defend and hold the school, Diocese and all personnel harmless from all claims arising out of or related to the proper administration of medication(s).

Date: _____ Parent/Guardian Signature: _____ Daytime Telephone: _____

Physician's Request for Administration of Medication at School During School Hours

TO THE PRINCIPAL: Please administer to _____ the following medication
FIRST NAME LAST NAME

_____ from _____ to _____ at _____
DATE DATE TIME

In the following dosage:

_____ for the following health problem: _____
NUMBERS OF PILLS, TEASPOONS, ETC.

Common side effects: _____

Special instructions: _____

Physician's Name (please print)

Physician's Signature

Telephone: _____

Date: _____
