

**PARENT/GUARDIAN MEDICATION CONSENT FORM
WITH PHYSICIAN'S ORDER FOR ADMINISTRATION**

Student _____ Date _____

School _____ Grade _____ Date of Birth _____ Age _____

Physician _____ Hospital/Clinic/Office _____

PHYSICIAN

In order for school personnel to administer the medication regime you have prescribed, please complete the following form.

Name and Dose of Medication	Form: Tablet, Capsule, Pill other _____	Number to be taken	Approximate Time of Day	Term Short/Long

Name of Medication and Side Effects:

Please indicate if medication above is PRN medication _____

Conditions under which PRN medication should be given are: _____

Physician Signature _____ Printed Name of Physician _____

Date _____

PARENT/GUARDIAN (Please fill out this portion of the form, after your child's physician has completed the top and return this form to the school office.)

- I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the written instructions of the physician as shown above.
- I also hereby agree to give my permission to the school principal/designee to contact the child's physician.
- I further agree to hold Roncalli Catholic Schools and all employees harmless in any and all claims arising from the administration of this medication at school.
- I agree to notify the school in writing at the termination of this request or when any change in the above is necessary.
(PLEASE NOTE ANY MEDICATION BROUGHT TO SCHOOL SHOULD BE IN DUPLICATE LABELED PHARMACY CONTAINER.)

(Signature of Parent/Legal Guardian)

Phone _____

Address _____

Date _____