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

This form must be completed and be on file in the school office in order for school personnel to administer any prescription medications.

Student Name _____

Name of Medication _____

Time (s) to be given _____

Number of days _____

Physician's Signature _____

PARENT/GUARDIAN

I hereby give my permission to authorized school personnel to distribute the above medication to my child according to the written instructions of the physician as shown above.

I further agree to hold Roncalli High School 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.

_____ _____

Signature of Parent/Legal Guardian Date

IMPORTANT: All medication must be in the original pharmacy bottle with specific patient information and must be kept in the school's main office.