MEDICATION PERMISSION FORM

St. Rose of Lima Catholic School & Early Childhood Center

STUDENT_____DATE_____

MEDICATION TO BE GIVEN, AMOUNT, ROUTE OF ADMINISTRATION, AND TIME TO BE ADMINISTERED:

_____

_____

WILL THERE BE ANY RESTRICTIONS FOR SCHOOL ACTIVITY WHILE STUDENT IS ON THIS MEDICATION? IF "YES", HOW LONG WILL RESTRICTIONS EXIST?

_____

I understand that the school principal or the principal's designee will give this medication. I further release the school and its personnel from any liability resulting from any untoward effects that this medication may causes when dispensed at school. I understand that if I do not agree to and sign the Medication Policy, that the medication will not be administered at school.

_____ _____

Signature of Parent or Legal Guardian **Date**

****

FOR OFFICE USE ONLY

Date	Time	Medication / Amount Given	Initials

Date	Time	Medication / Amount Given	Initials