SAN JOSE
CATHOLIC SCHOOL

Parental/Guardian Permission for the Administration of PRESCRIPTION MEDICATION

Student______________________________________Grade______________________

Name of Medication____

Prescribing Doctor__________________________ Prescription Number____________

Date of Prescription __________________ Quantity ______________

Dosing Information ____

I, _______________________________________, grant permission for the Clinic Aide
(Parent or legal guardian)

or the principal's designee to assist in the administration of the prescribed

medication to my child/legal ward, _______________________________________.
(Student's Name)

I certify that the prescribed medication is in its original container and that it is necessary, according to my child/legal ward doctor's instructions, for this medication to be provided during the school day. I understand that this medication will be given only according to the directions on the label as prescribed by the physician. Further, I agree to waive any claims of liability that may arise against any/all school, church or diocese personnel, relative to the administration of this medication to my child/legal ward according to these directions. I further understand that no later than the end of the school year any unused medication must be picked up or it will be destroyed.

____________________________ _______________________________________
Date **Signature of parent/legal guardian**