HOLY INFANT SCHOOL
Educating for Life's Journey

Parental Consent for Medication Administration

Date: _____ School: _____ Grade: _____

Student: _____

My child is to receive _____ (medication) according to the physician's directions to treat _____ (condition). This treatment will last from _____ to _____ or entire school year. I give my permission for this medication to be dispensed to my child at School. I give the School permission to contact the physician with questions regarding the medication.

My child has drug allergies to: _____

Parent/Guardian Signature: _____ Relationship to student: _____

Physician Consent for Medication Administration

Student: _____ Date: _____

Medication :_____ Dose: _____

Diagnosis or reason for treatment: _____

Observe for these side effects: _____

Physician's Signature: _____

Phone Number: _____

Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial