

**Parental Consent for Medication Administration**

Date: \_\_\_\_\_ School: **St. Clare of Assisi** Fax # 636-394-0359

Student: \_\_\_\_\_ Grade/Teacher: \_\_\_\_/\_\_\_\_\_

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

My child has drug allergies to: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Physician Consent for Medication Administration**

**Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Dose/Frequency:** \_\_\_\_\_

Diagnosis or reason for treatment: \_\_\_\_\_

Observe for these side effects: \_\_\_\_\_

**Signature:** \_\_\_\_\_

\*\*\*\*\*HEALTH ROOM USE ONLY\*\*\*\*\*

**Medication:** \_\_\_\_\_ **Dose/Frequency:** \_\_\_\_\_

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

Initial/Signature \_\_\_\_/\_\_\_\_\_

Initial/Signature \_\_\_\_/\_\_\_\_\_

Initial/Signature \_\_\_\_/\_\_\_\_\_

Initial/Signature \_\_\_\_/\_\_\_\_\_