

ST. MICHAEL SCHOOL

MEDICATION FORM

2016-2017

STUDENT'S NAME: _____ **GRADE** _____

I hereby authorize the staff of St. Michael School to administer the following medication in the following dosage to my child. I release St. Michael from all liability for administering the stated medication in the stated dosage.

MEDICATION _____

Condition for which prescribed _____

Possible side effects _____

Instructions for usage _____

Dosage _____ Times _____

Date(s) _____

Physician signature _____

Address _____ Phone _____

Parent/Guardian Signature _____

Work Phone _____ Cellular _____

Home Phone _____ Other _____

Note: This form is REQUIRED by the Archdiocese in the administering of any and all medication to students.

ALL PRESCRIPTION MEDICINE must be in its original container, with prescription label attached (this is the physician's written authorization), parent signature and accompanied with this form.

ALL OVER THE COUNTER MEDICINE (including Tylenol, Advil, Cough Drops, Calamine Lotion, Benadryl, etc.) MUST HAVE A PHYSICIAN'S SIGNATURE, be in its original container, and have on this form a parent signature.