

PARENT REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL AND RELEASE FROM LIABILITY FORM

This form must be presented to the school when a student returns with medication. St. Boniface School fax # (618) 692-8385

I/we, the undersigned parents/guardian of the minor child,	,
a student at <u>St. Boniface School</u> , hereby request said school to a	llow said child to
attend school in spite of his/her special health problem and to be given:	
(Name of medication)	_ prescribed by
(Physician's name):	for the period of:
(starting date): to (ending date):	
under the supervision of school personnel.	
The medicine is to be furnished by me and labeled by the physician or p	
child's name, doctor and pharmacy, name of drug, and the specific dosage and	_
at school. I/we assume all responsibility for any mistake in furnishing an incom-	
information. For, and in consideration of allowing said child to attend school in	-
special problem, we hereby release and discharge St. Boniface School	and/or any of
its agents or employees from any and all liability for any injury or damage to th	e health of said child
arising out of or resulting from the necessity of said child having to take medica	ation during school
hours.	
I/we have read, understand, and agree to the school's regulations concer	ming giving
medication at school.	
Signature Date	
Printed Name	
Address	
Telephone number:	

STATEMENT OF PHYSICIAN

Order for medication to:	St. Boniface School			
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Name of Student	Grade	Date		
Diagnosis	Name of med	Name of medication		
Dosage	Time of day to	Time of day to be administered		
Method of administration	Date to discor	ntinue		
Predictable side effects				
Contraindications				
Physician's signature	Physician's	Physician's telephone number		
Physician's address	City	State	Zip Code	

All medications will be kept in a locked cabinet. The principal will administer or designate an appropriate person to administer the medication.