ST. MICHAEL CATHOLIC SCHOOL
REQUEST FOR IN-SCHOOL ADMINISTRATION OF MEDICATION

Please administer_____ of_____
No. of pills, tsp., etc. (Name of medication)

To_____ Date_____
(Name of student)

At the following time(s) _____

On the following date(s) _____

WILL THERE BE ANY RESTRICTIONS FOR SCHOOL ACTIVITY WHILE STUDENT IS ON THIS MEDICATION? IF "YES", GIVE THE DATES FOR THESE RESTRICTIONS FROM START TO FINISH.

_____

I understand that the medication(s) will be administered by a person who is not medically trained.

I agree to hold the school harmless for the proper administration of medication provided by the parent/guardian and for the adverse drug reactions or side effects.

I agree to be responsible for maintaining an adequate supply of medication at the school to meet the child's needs.

_____
Signature of Parent/or Legal Guardian

I agree to insure administration of the above medication, according to Diocese of Victoria policy.

_____
Principal

Revised 11/2017