ST. GEORGE SCHOOL
PARENTAL CONSENT FOR MEDICATION ADMINISTRATION

Please give my child,_____,
(Name of Child)
the medication as ordered below by Dr._____.

I accept the rules of the school concerning the giving of medication, including the following:

1) The medication must be prescribed by a physician, who must also certify in writing to the school principal that it is NECESSARY for the child to receive the medication during school hours. This certification shall be obtained by having the physician complete and sign the form below.
2) The medication must be brought to the school by an adult in a container with label from the pharmacy, showing name of medication, dosage, child's name and the time to be given.
3) This school and its employees are held harmless for any unintentional mistakes or oversight in keeping or giving my child's medication.

Medication(s) administered at home: Time(s):_____
Dosage:_____
Duration:_____

_____
(Parent or Guardian Signature)

Parent or Guardian Address_____
Home Telephone #: (_____)_____ Work Telephone #:(_____)_____

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PHYSICIAN'S ORDER FORM

(To be completed by physician only.)

I hereby certify that it is necessary for the medication listed below to be given during school hours to:_____
(Name of Child)

Name of medication:_____ Diagnosis:_____
Amount of dosage:_____ Time to be given:_____
Possible side-effects:_____ Date to begin:_____
_____ Date to end:_____
Known drug allergies:_____
Contra-indications:_____
Comments:_____
Physician's signature:_____ Date:_____
Office telephone #:_____