SACRED HEART CATHOLIC SCHOOL

7951 46th Way North, Pinellas Park, FL, 33781 † Tel. (727)-544-1106 † www.sacredheartpinellaspark.org

Parent's/Guardian's Request for the Administration of Medication by School Personnel

I hereby authorize, request, and give my consent to the Principal, or his/her delegate (school nurse or other responsible person) to store, supervise, and/or administer the following medication to my child. It is impossible to arrange for the medication to be taken at home; therefore it must be administered during the school hours.

Name of Student: _____ Grade: _____

Name of Medication: _____

(Note: Prescription medication MUST be in original container)

Dosage: _____ Expiration Date: _____

Route of Administration: _____

Time(s) of day to be administered: _____

Note: It is the student's responsibility to come to the school office/clinic at the proper time.

Date to begin: _____ Date to complete: _____

I release the Diocese of St. Petersburg and Sacred Heart Catholic School and any and all employees and staff therein, from any liability and/or damages resulting from the consequences of allowing school personnel to administer the above medication, and/or any adverse reactions of my child taking, or failing to take, this medication at the prescribed time. I understand that I have the primary responsibility for administration of medication, but in my absence, I consent and authorize the school to assist me with this obligation. I further agree to keep the school informed in writing of any revisions to the Physician's prescription and directions.

Parent/Guardian Name **(Please Print)**: _____

Parent/ Guardian Signature: _____

Date: _____