HOLY INFANT SCHOOL
Educating for Life's Journey

Parental Consent for Medication Administration

Date: ____________________

Student: ____ Grade: ________

My child is to receive _________________________ (name of medication) according to the physician's directions given for _____________________________________. This treatment will last ____________________________________. I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication. My child has ___________________________ drug allergies.

Signature: ____

Relationship to student: __________________________________

Physician Consent for Medication Administration

Date: __________________ Name of Student: ____

Medication: ____ Dose: ___________________________

Time Interval: _____________________________

Diagnosis or reason for treatment: ____

Side Effects to look for: ____

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Restrictions: ____

Signature: ____