St. Pius X School
Medication Administration Consent Form

If your child requires medication during school hours, whether prescription or over- the-counter, we must have this form completed and signed. All medications must be in their original containers with labels affixed. Prescription medications must have the child's name on the label. Medications containing narcotics or sedation for pain relief will not be administered at school for the child's safety. **This form must be signed by a physician.**

Student's Name:_____ Date of Birth:_____Homeroom: _____

This form applies for the duration of the _____ School Year.

** Prescription Medications**

Medication	Dosage	Time to be administered or frequency	Special Instructions/Other

If one of the above medicines is used for asthma treatment, is the student able to self-administer? Yes___ No ___

If Yes - I agree to indemnify and hold harmless the school and its employees against any claims relating to the self-administration of asthma medication by the student. Parent/Guardian initials _____

Over-the-Counter Medications

Medication	Dosage	Time to be administered or frequency	Special Instructions/Other

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Physician Name: _____ Physician Phone #: _____

Physician Signature_____ Date:_____

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I grant the school nurse or his/her designee permission to perform/assist in the administration of medication to or for my child during the school day, including when he/she is away from school grounds at official school events. I agree to indemnify and hold harmless the school and its employees against any claims relating to the administration of medication.

Parent/Guardian Name _____ Phone Number: _____

Parent/Guardian Signature _____ Date:_____