

ST. BERNARD SCHOOL

ADMINISTRATION OF MEDICATION FORM

This completed form shall be on file for each child requiring medication. **FAX (337) 332-5894**

Name _____ Age _____ Grade _____

Address _____ Phone No. _____

PARENT'S RELEASE FROM LIABILITY

For and in consideration of allowing said child to attend school in spite of his/her specific health problem, we hereby release, relieve and discharge the St. Bernard Advisory Council, and/or any of its agents or employees from any and all liability for any injury or damage to the health of said child arising out of, or resulting from the necessity of said child having to take medication during school hours.

I have read, understand and agree to the school's regulations concerning giving medication at school.

Signature of Parent or Guardian

Date

The following information must be completed by the physician.

1. Diagnosis _____

2. Reason for medication _____

3. Medication, dosage and frequency _____

4. Anticipated reactions of child to medication _____

5. Duration of medication _____

Date

Signature of Physician

Telephone No.

Print name of Physician

Address