Twin City Catholic Educational System

Twin City Catholic Educational System

St. Mary Elementary Campus
540 Second Street
Menasha, WI 54952

Administration of Medication Consent Form 2009-2010 School Year

Name of Student: _____ DOB: _____
Parents/Guardians: _____ Phone # _____

Medication Name:_____
Prescription/Dosage:_____ Time to be Administered _____
Route (Circle one): by mouth inhalation injection

Start Date: _____ Discontinue Date: _____

*** **All medications must come in the original container provided by pharmacy or store**

Reason for Medication: _____

Precautions/Special Instructions:

_____

_____

Prescribing Physician:_____
Physician's Address: _____ Phone # _____
Physician's Signature:_____

Release Statement:

I hereby give my permission to the school personnel to give the medication to my child according to the directions stated above and to contact the child's physician if necessary.

I understand it is my responsibility to see that the medication and/or other necessary supplies are delivered to the school office and to pick up any remaining medication and/or supplies within one week after the last day of the school year. Medication remaining at school beyond this stated time will be discarded.

I further agree to hold Twin City Catholic Educational System/St. Mary Elementary Campus and above personnel harmless in any and all claims arising from the administration of the medication at school. I agree to notify the school in writing when any changes in the above order are necessary.

_____ _____
Signature of Parent/Legal Guardian Date

Approved by: _____ _____
Signature of Administrator Date