PARENT/GUARDIAN AUTHORIZATION FOR PRESCRIPTION MEDICATION

Student's Name:_____Date of Birth:_____

We, the undersigned, are the parents (guardians) of _____, who lives with us at

_____.

The doctor had prescribed that this child be given _____in accordance with his/her written instructions, which are hereto attached, and we desire that the personnel at St. Pius X School give the child assistance in the taking of this medication. It is to be given at the following dates and times:

		_____	AM
_____through _____		_____	PM
m/d/y	m/d/y	_____	As Needed

We hereby agree to indemnify and hold forever harmless all employees of the St. Pius X School against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement of indemnity.

Please read the above carefully before signing. No child will be assisted in taking medication until this form has been signed and delivered to the school.

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

_____

My son/daughter has the following food or drug allergies:

_____

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

Licensed Physician _____

Address _____

I give permission for my son/daughter to self-administer medication, if the School Nurse determines it is safe and appropriate.

_____Yes _____ No

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature: _____Date:_____

Relationship to Student: _____