SAN JUAN DEL RIO CATHOLIC SCHOOL

PARENT PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS

The Health Room for our school is the office. All students taking medications will receive them in the school office. This allows for a record keeping system.

All medications **MUST** be in its original container. Please ask your pharmacist to give you a duplicate container for school use.

PLEASE RETURN THIS FORM WITH THE PROPER CONTAINER FOR YOUR CHILD.

Student Name: _____ DOB: _____

Homeroom: _____

Medication: **1.** _____ Dose: _____ Times per day: _____

Date to Start: _____ Date of last dose: _____

2. _____ Dose: _____ Times per day: _____

Date to Start: _____ Date of last dose: _____

3. _____ Dose: _____ Times per day: _____

Date to Start: _____ Date of last dose: _____

I, _____, grant permission for the school office employee or volunteer to assist in the administration of the above listed medication for my child, _____. I certify that the medication is in its original container and that it is necessary for this medication to be provided during the school day. I understand that the medication will be given only according to the directions on the label.

_____

Parent Signature Date