Physician's Request for the Administration of Medication
St. Francis de Sales School
Fax: 740-345-9768

Name of Student ____ **DOB** ___________

Medication and Dosage or Procedure required ________________________________

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Possible Reactions ____

Special Instructions ____

Medication to be continued as above until __________________________________

Physician's Signature ___________________________________ **Date** _____________

Physician's Phone Number ______________________

Persons authorized to administer the medication for the school are:
1. Julie McNulty RN, LSN (School Nurse), or Substitute
2. Trained Personnel

Parent release for the administration of medication at School

I, the undersigned, request that medication be administered to my child in accordance with the instructions of the child's physician as requested above. Further, I understand that the school personnel are not legally obligated to administer medication to any child, and therefore, I agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it was administered and to identify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them. Further, I agree (1) to deliver the medication to the school, (2) to notify the school if there is a change of physicians, (3) to notify the school if the medication, the dosage or the procedure is changed, or to be eliminated. Lastly, I acknowledge the fact it is the student's responsibility to come to the office for the medication unless physically unable to do so.

Parent's Signature _____________________________________ **Date** _____________