

St. Aloysius Catholic School

PARENT'S PERMISSION AND RELEASE FOR SCHOOL PERSONNEL TO OVERSEE TAKING OF MEDICATION AND RELEASE FROM LIABILITY

I hereby request and give the Principal or other appropriate school personnel the right to oversee the taking of prescribed medication listed below. I understand that the school undertakes no responsibility to diagnose, treat or dispense medication but will only administer or oversee the medication stated as directed and authorized. I agree to submit a revised physician's statement if any of the information changes.

Name of Child:		
Name of drug or medication:		
Dosage:	at	(time)
Date:		
Other medication or drugs child is taking:		
In consideration for the overseeing and admin and indemnify the Diocese of Toledo, the Toledo Cath responsible school and his/her designee and any othe medication or drugs herein described, from all claims, from the overseeing or administration of the medicati terms.	olic/Privates Schools, St. Aloysius School, r persons involved in the overseeing and demands, actions, judgments, and execu	the principal of the administration of tions which may arise
Date:	Parent/Legal Guardian	Phone
	Parent/Legal Guardian	Phone

^{*}If parent share custody under a court agreement, both must sign.



St. Aloysius Catholic School

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of student	Address of student		
enrolled in grade, at	olled in grade, at St. Aloysius Catholic School is under my care and should receive		
Name of drug and dosage			
At the following times or intervals			
beginning	•		
Specific instructions for administratio	on and storage:		
Possible adverse reactions of side efformation	ects to watch and report:		
Expiration of this request:			
Other medication the child is taking:			
I understand that the school will not	independently verify the above instructions.		
 Date	Physician's Signature		

Physician's Phone number