## REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL AND RELEASE FROM LIABILITY FORM

This must be presented to the school when a student returns to school with medication.

I/We, the undersigned parents/guardian of the minor chil	
A student at BLESSED SACRAMENT SCHOOL, her	eby request said school to allow said child to
attend school in spite of his/her special health problem as	
from under the superv	to
under the superv	vision of school personnel.
The medicine is to be furnished by me and labeled by the name, doctor and drug store, name of drug, and the speci assume all responsibility for any mistake in furnishing an	ific time it is to be given at school. I/We
For and in consideration of allowing said child to attend hereby release and discharge BLESSED SACRAMENT employees from any and all liability for any injury or dator resulting from the necessity of said child having to tal medication will be in its original container.  I/we have read, understand and agree to the school's registhool.	SCHOOL and/or any of its agents or mage to the health of said child arising out of see medication during school hours. All
school.	
PLEASE PRINT	
Parent's Name	Date
Address	Home Phone
	Work Phone
Parent's Signature	

(physicians signature required)

<sup>\*</sup> please see reverse, also

## PHYSICIAN'S STATEMENT

This information must be provided to the school when the student returns to school with medication. This form must be filled out and signed by the physician. The completed form must be on file with the school prior to any medications being taken by a student.

Eye		
Name of Student	Grade	Date
<u>and the services of the second to </u>		
Diagnosis	hora et se	Name of Medication
Dosage		Time of Administration
		Time of Administration
Method of Administration		Date to Discontinue
Predictable Side Effects		
Contraindications	9	
Physician's Signature	$\overline{\text{Tel}}$	lephone Number
Address	Cit	y/State/Zip