ST. MARY SCHOOL MEDICATION DOCUMENTATION & AUTHORIZATION

Student Name _____ Grade _____ School Year 2017 - 2018

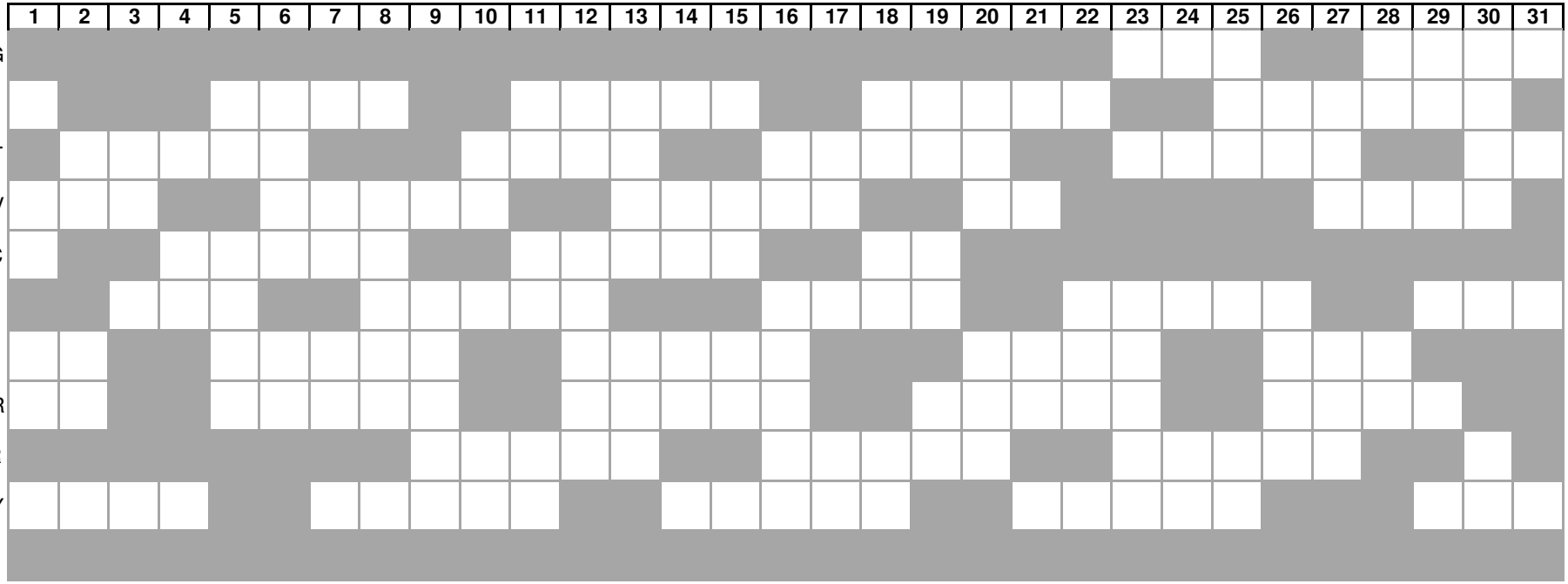
Medication _____ Dosage _____ @ Time _____

Starting Date _____ Ending Date _____

Possible side effects _____

_____ _____ _____

Physician's Signature | Physician's Phone | Date



* Initial appropriate box after dispensing medicine.

x= No School	A= Absent	E= Error	O= No Medication Available	F= Field Trip

PARENT'S STATEMENT: In consideration for the overseeing and dispensing of medication for the above referenced child, I hereby release and discharge the Toledo Catholic/Private Schools, the Principal of the responsible school, his/her designees, and any other persons connected with the overseeing and dispensing of medication or drugs herein described, from all claims, demands, actions, judgments, and executions which may arise from the overseeing or dispensing of the medication. We (I) agree to notify the school personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician. The undersigned have read this and understand all of its terms.

I request that medication be administered to my child according to the directions of the licensed prescriber in the above section. I also authorize the exchange of

Written permission must be obtained from the licensed provider before prescribed medication can be administered during school hours. Parents' permission IS REQUIRED for all medication (prescribed and over-the-counter.) Medication must be in the original labeled container in which it was dispensed.

_____ _____

Parent's Signature | Date