The Roman Catholic Diocese of
BATON ROUGE
CATHOLIC SCHOOLS OFFICE

St. Michael the Archangel Diocesan Regional High School

PARENTAL CONSENT FOR MEDICATION ADMINISTRATION

Please give my child, _____, the medication as ordered below by Dr. _____.

I accept the rules of school concerning the giving of medication, including the following:

1.) The medication must be prescribed by a physician, who must also certify in writing that it is NECESSARY for the child to receive the medication during school hours. This certification shall be obtained by having the physician complete and sign the form below.
2.) The medication must be brought to the school by an adult in a container with label from the pharmacy, showing name of medication, dosage, child's name and the time to be given. Supply must not exceed one month's supply. The empty container will be sent home.
3.) This school or designated person administering the medication are held harmless for any unintentional mistakes or oversight in keeping or giving my child's medication.

Medication administered at home:

Time(s): _____ Dosage: _____ Duration: _____

Parent/Guardian Signature: _____

Parent/Guardian Address: _____ Phone #: _____

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Physician's Order Form (to be completed by physician only)

I hereby certify that it is necessary for the medication listed below to be given during school to:

_____

Name of medication: _____

Diagnosis: _____

Amount of dosage: _____

Time to be given: _____ Date to be given: _____

Date to begin: _____ Date to end: _____

Comments: _____

Physician's Signature: _____

Date: _____

Office Phone Number: _____