St. Patrick School

Diocese of Lansing

WAIVER OF LIABILITY

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

School Year_____ Date_____

Student Name: _____Class _____

Medication to be administered:_____

Dosage: _____ Frequency: _____

Time of day: _____(mid-day, hourly, etc.)

Comments:_____

This authorization expires: _____

Physician Signature _____ Date _____

I understand and agree that this medication will be administered to my child under the supervision of authorized personnel such as the secretary, principal or teacher. I hereby waive any claim against St. Patrick School, the Diocese of Lansing and its employees on account of the distribution of this medicine. I further agree that you may contact the physician who prescribed the medicine and I hereby authorize him/her to release to you any and all information regarding my child's condition, treatment, history, prognosis or any other facts in his possession concerning the child.

• **Prescription medication shall have the pharmacy label indicating the Physician's name, child's name, and strength of the medication.**

• **Medication shall be given to the child listed on the label only and will be given in accordance to the label instructions.**

• **Medication must be in its original container.**

• **Dosage for non-prescription medicine shall not exceed the label instructions for the particular age of the child.**

• **No child will be allowed to take medicine without supervision.**

_____ _____

Parent signature Parent signature