

**PHYSICIAN'S STATEMENT REGARDING  
ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL**

**Please schedule medication outside of the school hours whenever possible.**

1. Name of student \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

2. Address \_\_\_\_\_ Telephone \_\_\_\_\_

3. Condition for which medication is to be given \_\_\_\_\_

4. Name of medication \_\_\_\_\_

5. Method of administration: Oral \_\_\_ Inhalator \_\_\_ Injection \_\_\_ Other \_\_\_

6. Dose \_\_\_\_\_ Schedule of doses \_\_\_\_\_

7. The medication is to be continued as above until \_\_\_\_\_

8. Precautions advised \_\_\_\_\_

Possible reactions to medication \_\_\_\_\_

Actions to be taken in case of reaction to medication \_\_\_\_\_

9. Check one below:

\_\_\_\_\_ I give this student permission to **self-administer** the above medication.

\_\_\_\_\_ I authorize designated school personnel to administer the above medication.

10. Print name and address of physician \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

.....  
**PARENT'S OR GUARDIAN'S REQUEST FOR  
ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL  
AND WAIVER AND RELEASE FROM LIABILITY**

The undersigned hereby requests St. Cecilia School to assist \_\_\_\_\_  
in the matters set forth in the above Physician's statement.

(Over)

11. Name of parent/guardian \_\_\_\_\_

12. Telephone where a parent/guardian can be reached during the school day \_\_\_\_\_

13. Language (s) used at home \_\_\_\_\_

I will notify the principal of the school immediately if there is a change in my child's medication schedule or if the physician prescribing the medication is no longer providing health care for my child.

I understand it is my responsibility to send the medication to school in the **original pharmacy container** including the child's name and the doctor's instructions

Check one below:

\_\_\_\_\_ I give \_\_\_\_\_ permission to self-administer the above referenced medication.

\_\_\_\_\_ I authorize designated school personnel to administer this medication.

I understand that St. Cecilia School reserves the right to discontinue its involvement in the above referenced administration of medicine.

I UNDERSTAND THAT ST. CECILIA SCHOOL IS NOT LEGALLY OBLIGATED TO STORE OR ADMINISTER MEDICATION FOR STUDENTS. THEREFORE, IN CONSIDERATION FOR THE ABOVE REFERENCED ARRANGEMENT, THE UNDERSIGNED DOES HEREBY RELEASE AND DISCHARGE THE ARCHDIOCESE OF SAN FRANCISCO, ITS CONSTITUENT ORGANIZATIONS, INCLUDING, BUT NOT LIMITED TO ST. CECILIA SCHOOL/ PARISH AND THEIR OFFICERS, AGENTS AND EMPLOYEES, FROM ANY AND ALL CLAIMS FOR PERSONAL INJURIES OR PROPERTY DAMAGE THAT I OR MY CHILD MAY SUFFER AS A RESULT OF THIS ARRANGEMENT WHETHER OR NOT SUCH INJURIES OR DAMAGE ARE CAUSED BY THE NEGLIGENCE (WHETHER ACTIVE OR PASSIVE) OF ANY OF THE ENTITIES OR INDIVIDUALS NAMED OR DESCRIBED ABOVE.

\_\_\_\_\_  
Signature of Parent/Guardian

ONE MEDICATION PER FORM, PLEASE

Return completed form to the principal.