ST. BERNARD SCHOOL

ADMINISTRATION OF MEDICATION FORM

This completed from shall be on file for each child requiring medication. **FAX (337) 332-5894**

Name ____ Age ________ Grade ___________

Address ____ Phone No. _________________

PARENT'S RELEASE FROM LIABILITY

For and in consideration of allowing said child to attend school in spite of his/her specific health problem, we hereby release, relieve and discharge the St. Bernard Advisory Council, and/or any of its agents or employees from any and all liability for any injury or damage to the health of said child arising out of, or resulting from the necessity of said child having to take medication during school hours.

I have read, understand and agree to the school's regulations concerning giving medication at school.

____ ______________________________
Signature of Parent or Guardian Date

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The following information must be completed by the physician.

1. Diagnosis ____
2. Reason for medication ____
3. Medication, dosage and frequency ____
4. Anticipated reactions of child to medication ____

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5. Duration of medication ____

____ ______________________________
Date Signature of Physician

____ ______________________________
Telephone No. Print name of Physician

____
Address