Assumption Parish School
4709 Mattis Road
St. Louis, MO 63128
314.487.6520

Rooted In Faith, Growing In Grace

Parental Consent for Medication Administration to their Child

Date: _____ School:_____

Student: _____ Grade: _____

My child is to receive _____ medication according to the physician's directions given for _____.

This treatment will last _____.

My child has _____ drug allergies.

I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.

I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.

Signature: _____

PRINT NAMES/Parent(s)/Guardian(s): _____

Relationship to student: _____

Physician Contact Information: _____