Faith. Academics. Service.
St. Anthony School

PARENT OR GUARDIAN MEDICATION CONSENT FORM 2023-2024

Full Name of Child

_____

Name of drug and dosage (I.e.: Tylenol, Ibuprofen, cough drops, allergy medication, inhalers)

_____

Hour it is to be given

_____

Name of Physician

_____

Phone # _____

Reason for medication

_____

The school secretaries will be administering the medication during school hours.

I hereby give my permission to school staff to give the medication to my child according to the directions stated above and to contact the child's physician.

I further agree to hold St. Anthony's School and its staff members harmless in any and all claims arising from the administration of the medication at school.

I agree to notify the school in writing at the termination of this request or when any change in the above orders are necessary.

_____

Signature of Parent or Legal Guardian Date

*******Extra forms are available at the School Office.

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PHYSICIAN ORDER FOR MEDICATION ADMINISTRATION 2023-2024

Date Order Effective From: _____

To: _____

Name of Student _____

Address _____

Telephone Number _____

School _____Grade _____

Physician's Telephone Number _____

Diagnosis _____

_____

Medication/dose/route/frequency/duration _____

_____

If PRN (as the situation demands) medication, conditions under which medication should be given:

_____

_____

State the conditions/circumstances under which direct contact shall be made with me should the student receiving the medication develop a condition or has a reaction to the medication.

_____

_____

_____

Physician's Signature _____

Date _____