Rapid City Catholic School System

MEDICATION PERMISSION FORM

DATE: ____________ HOME PHONE: ______________ WORK PHONE: ______________

STUDENT: ________________________________ ROOM: _____ D.O.B./AGE: ____________

***We encourage medication be taken outside of school hours if possible.**
****SES/STM employees have limited or no knowledge of administering medications.**

TO BE COMPLETED BY THE PARENT OR AUTHORIZED PRESCRIBER
(All areas MUST be completed, where applicable)

Name of Medication: ____

Reason for Medication: ____

Instruction (dosage, form, time schedule, duration):____

____

Restrictions, precautions, and/or important side effects: ______________________________

____

____ __________________________

Physician's Name **Physician's Phone Number**

I give permission for **(Child's Name)** ____________________________________ to receive the above medication at school according to school policy.

I understand that all medications shall be provided by me as parent/guardian in a container showing the name and telephone number of the pharmacy, student's name, physician's name, medication name, dosage and time to be given along with all special instructions concerning administering the medication.

I understand that it is the responsibility of the child to come to the office to take his/her medication.

I release St. Elizabeth Seton, its board, staff and volunteers from all liability for injury or adverse consequences resulting from the administration of the above medication to my child.

_____________________ ____

Date Signature/Relationship

***Medication will not be given until this form is completed in its entirety and returned to school.**
***This applies to all medication including over the counter medications such as tylenol, aspirin, inhalers, etc.**
***Any change in this request must be made in writing.**
***Medication requests must have annual renewal.**