

Parental Consent for Medication
St. Pius X High School – Festus, MO
(valid for current school year)

Date: _____

Name of Student: _____ Grade: _____

Drug Allergies: _____

Parental consent for administering medication through the main office

I give my permission for these medications to be administered to my child at school. I understand and acknowledge that any medication administered to my child during school will not be administered by a medical professional. I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representatives, from any liability that may arise from administering medication to my child.

Parent/Guardian Signature(s): _____ Phone# _____

MEDICATION	DOSE	FREQUENCY	REASON	SIDE EFFECTS TO LOOK FOR	RESTRICTIONS

Parental consent for student to self administer medication

My child may carry with him/her and administer his/her own medication. I realize the school is not responsible for the benefits or consequences of the medication. The school bears no responsibility for assuring that the medication is taken. I also understand that if the student abuses the policy of carrying his/her medication, the medication will be confiscated and the privilege will be revoked.

Parent/Guardian Signature(s): _____ Phone# _____

MEDICATION	DOSE	FREQUENCY	REASON	SIDE EFFECTS TO LOOK FOR	RESTRICTIONS