

Parental Consent for Medication Administration to their Child

Date: _____ PSR : _____

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

Signature: _____

Relationship to student: _____

Physician Contact Information: _____