Holy Spirit CATHOLIC SCHOOL

MEDICATION ADMINISTRATION RELEASE FORM

DATE: _____

Name of Child: _____ **Date of Birth:** _____ **Grade/Class:** _____

Parent/Guardian: _____ **Phone No.:** _____
(print)

I hereby request and authorize school personnel to administer my child's prescribed medication as directed by our doctor or over-the-counter medications, including aspirin related products & cough drops.

> **"Administration of medication to pupil; liability.**
> A school administrator, teacher, or other school employee designated by the school administrator, who in good faith administers medication to a pupil in the presence of another adult pursuant to written permission of the pupil's parent or guardian and in compliance with the instructions of a physician is not liable in a criminal action or for civil damages as a result of the administration except for an act or omission amounting to gross negligence or willful and wanton misconduct."
>
> Michigan Compiled Laws, 1982 (380.1178)

Signature: _____
(Parent /Guardian)

PARENT/DOCTOR'S ORDERS & DIRECTIONS

You are hereby directed to give to _____ his/her medication _____
(Name of Child) (Name of Medication)

in the amount of _____tablets/capsules or _____teaspoons at _____ a.m./p.m. daily, or as follows _____

_____

Duration: _____

Possible Side Effects: _____

Print or Type Name: _____ **Phone No.:** _____

Signature: _____
(Parent/Physician)

IMPORTANT: By Holy Spirit School policy, medication must be sent directly from the pharmacy or physician's office or brought to school by the parent/guardian in the original pharmacy container.

Date: _____