

**APPENDIX B**

**ALL SAINTS CATHOLIC SCHOOL  
Parent/Guardian Medication Consent Form**

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Grade \_\_\_\_\_

I hereby grant permission for school personnel to supervise the medication routine prescribed below for the above named child.

I agree to hold All Saints Catholic School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

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

Name of Medication \_\_\_\_\_

Directions (Please include specific dosage and times): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE NOTE:**

- § Before a medication will be administered by the school or agent thereof, a MEDICATION CONSENT FORM shall be completed and returned to the school. You do not need to return this form if you are not sending medication to school.
- § **All medications must be in a container labeled from a pharmacy or manufacturer.**
- § If times of medication administration are required to be sent home, please include a small spiral notebook with the medication.
- § If medication needs to be sent home at the end of the day, please indicate above. Otherwise all medications will remain in the school office until picked up by a parent/guardian.