



## PERMISSION TO ADMINISTER MEDICATION

This form must be returned to St. Patrick Faith Formation Office. A physician's order is necessary for over-the-counter or prescription, short-term, and long-term medications. We cannot and will not administer any medication without it.

**The following information must be completed by the parents:**

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

Address \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Phone Numbers: \_\_\_\_\_

Class Information: Grade: \_\_\_\_\_ Day: \_\_\_\_\_ Time: \_\_\_\_\_

Instructor's Name: \_\_\_\_\_

Other medications the child is taking: \_\_\_\_\_

I hereby confirm my primary responsibility to administer medications to my child. However, in the event that I am unable to do so, I hereby authorize St. Patrick Faith Formation Office and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child (or allow my child to self administer, while under the supervision of the employees or agents of St. Patrick Parish)

Lawfully prescribed medication in the manner described below. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY CHILD TO BE PREFORMED BY AN INDIVIDUAL OTHER THAN A NURSE OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed is so administered or attempted to be administered, I waive any claims I might have against St. Patrick Faith Formation, its employees and agents St. Patrick Parish and the Catholic Diocese of Superior, arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify St. Patrick Faith Formation, its employees and agents, St. Patrick Parish and the Catholic Diocese of Superior, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important Information About Medications**

The medication is to be brought to the Faith Formation Office in its original pharmaceutical container, clearly marked with the child's name, the medication name, and pertinent information. Duplicate prescription bottle can be obtained from your pharmacist. Over-the-counter medication shall be brought in its original, unopened container with the seal unbroken. We will not administer any medication sent to Faith Formation Office in Tupperware, baggies, envelopes, etc.

The parents must report immediately any change in prescription or dosage. New permission forms must be obtained for each charge.

*The Permission to Administer Medication Form will be kept in the Faith Formation Office.*

**The following information must be completed by the physician:**

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_

Physician's Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Medication _____ Dosage _____
Route of Administration _____ Frequency _____ Times _____
Intended Effect of Medication _____
Possible Side Effects _____
Additional Instruction/Comments _____ _____
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Route of Administration _____ Frequency _____ Times _____
Intended Effect of Medication _____
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Name of Medication _____ Dosage _____
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Intended Effect of Medication _____
Possible Side Effects _____
Additional Instruction/Comments _____ _____

The above medication as prescribed is necessary for this child to receive during their Faith Formation session in order to maintain an optimal state of health.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_