

ST. BERNARD SCHOOL

ADMINISTRATION OF MEDICATION FORM

This completed form shall be on file for each child requiring medication. **FAX (337) 332-5894**

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

PARENT'S RELEASE FROM LIABILITY

For and in consideration of allowing said child to attend school in spite of his/her specific health problem, we hereby release, relieve and discharge the St. Bernard School Board, and/or any of its agents or employees from any and all liability for any injury or damage to the health of said child arising out of, or resulting from the necessity of said child having to take medication during school hours.

I have read, understand and agree to the school's regulations concerning giving medication at school.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

-----  
The following information must be completed by the physician.

1. Diagnosis \_\_\_\_\_

2. Reason for medication \_\_\_\_\_

3. Medication, dosage and frequency \_\_\_\_\_

4. Anticipated reactions of child to medication \_\_\_\_\_

\_\_\_\_\_  
5. Duration of medication \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Print name of Physician

\_\_\_\_\_  
Address