St. Malachy Parish School

PARENT/GUARDIAN RELEASE FOR ADMINISTRATION OF MEDICATION

FAMILY LAST NAME____

Please complete the following required information for your student/s if you request medication to be administered during school hours.

Name________________________________ **Medication Allergies**________________________

Medication Name	Strength	Dose	Time/s To Be Given	Date/s To Be Given

Name________________________________**Medication Allergies**_________________________

Medication Name	Strength	Dose	Time/s To Be Given	Date/s To Be Given

Name________________________________**Medication Allergies**________________________

Medication Name	Strength	Dose	Time/s To Be Given	Date/s To Be Given

I hereby give permission for St. Malachy Parish School Staff to oversee administration of the medication specified above for my child/ren.

Parent/Guardian Signature(s):__________________________________**Date:**______________

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