SAINT JOHN
CATHOLIC SCHOOL

Permission for Medication

Name of Student _____

School St. John Catholic Elementary School (Lawrence, KS) Grade _____

Medication _____ Dosage _____

Time of day medication is to be administered _____

Possible side effects _____ # of days given at school _____

Physician _____ Office Phone _____

I hereby give permission for _____ to take the above prescription at school as prescribed. I understand that it is my responsibility to furnish this medication.

Signature of parent/guardian _____ Date_____

Prescription medication must be brought to school in a container appropriately labeled by the pharmacist or physician with name of medication and dosage. Over-the-counter or non-prescription medication must be in its original container.

Any school employee who administers any drug in accordance with written instruction from physician shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

Please return this completed and signed form to the school office.