

Shiner Catholic School Medication Form

Date: _____

Student: _____

Medication to be given: _____

Amount: _____

Route or administration: _____

Time(s) to be administered: _____

WILL THERE BE ANY RESTRICTIONS FOR SCHOOL ACTIVITY WHILE STUDENT IS ON THIS MEDICATION? IF "YES," HOW LONG WILL RESTRICTIONS EXIST?

I understand that this medication will be given by the school principal or the principal's designee. I further release the school and its personnel from any liability resulting from any untoward effects that this medication may cause when dispensed at school. I understand that if I do not agree to sign the Medication Policy, the medication will not be administered at school.

Signature of Parent/Legal Guardian

Date