Parental Consent for Medication Administration to their Child

Date:_____

School: Saint Raphael the Archangel
6000 Jamieson Avenue
St. Louis, MO 63109
Office: 314-352-9474
FAX: 314-351-7477

Student:_____ Grade:_____

My child is to receive_____medication according to the physician's directions given for_____. This treatment will last_____. I give my permission for this medication to be dispensed at school. The school has my permission to call the physician with any questions regarding the medication. My child has_____drug allergies.

Parent/Guardian Signature:_____

Relationship to student:_____

Physician Consent for Medication Administration

School: Saint Raphael the Archangel
6000 Jamieson Avenue
St. Louis, MO 63109
Office: 314-352-9474
FAX: 314-351-7477

Date:_____ Name of Student:_____

Medication:_____ Dose:_____

Time Interval:_____

Diagnosis or reason for treatment:_____

Side Effects to look for:_____

_____

Physician Signature:_____