

DIOCESE OF CORPUS CHRISTI DEPARTMENT OF SCHOOLS
REQUEST AND CONSENT
FOR IN-SCHOOL ADMINISTRATION OF MEDICATION TO STUDENT

Please administer _____ of _____
(No. of pills, amount) *(Name of medication)*

to _____, _____, _____
(Name of student) *(Date of birth)* *(grade)*

at the following time(s) _____

on the following date(s) _____ .

I understand that the medication(s) will be administered by a person who is not medically trained.

I agree to hold the school harmless for the proper administration of medication provided by the parent/guardian and for adverse drug reactions or side effects.

I agree to be responsible for maintaining an adequate supply of medication at the school to meet the child's needs.

(Parent/Guardian signature) *(date)*

I agree to ensure administration of the above medication according to diocesan policy.

(Principal signature) *(date)*