

**ST. CATHERINE OF SIENA SCHOOL
PARENTS'S PERMISSION TO ADMINISTER MEDICATION**

I/we hereby request that my/our child be administered the drug _____ that we have supplied to St. Catherine School. This medication should be given according to the following schedule:

TIME OF DAY _____
DOSES PER DAY _____
AMOUNT OF DOSAGE _____

The medication will be kept in the school office and will be administered under the supervision of the personnel of St. Catherine School.

I/we understand that it is the responsibility of my/our child to come to the school office to take this medication. I/we release and agree to indemnify St. Catherine School and its personnel from any liability for any accident or injuries that may occur in the administration or storage of the medication.

I/we recognize that I/we are fully responsible for any legal liability resulting from the actions of my/our child while being administered this medication.

Witness my/our signature(s), this ____ day of _____, 2004

Father/Guardian: _____

Mother/Guardian: _____

STUDENT PARTICIPANT

I understand that it is my responsibility to come to the school office at the designated time to receive my medication.

Student Participant _____

For office use only: _____
