ST. JOHN FISHER SCHOOL
MEDICATION AUTHORIZATION FORM

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Date: _____

Student Name _____ Grade _____

Address: _____

Medication _____
Dosage _____
Time of Administration: _____
Method of Administration: _____

Diagnosis requiring medication: _____

Possible side effects _____
Contraindications _____

Physician's Signature _____
Physician's Name Printed _____
Physician's Phone Number _____

PARENT/GUARDIAN AUTHORIZATION FORM

I/We, the parents/guardian of _____, a student at St. John Fisher School, hereby authorize St. John Fisher personnel to administer the above medi~~cation~~ to our child during school hours.

We release, relieve and discharge St. John Fisher School and or any of its agents or employees from any and all liability for any injury or damage to the health of said child arising out of or resulting from the necessity of said child having to take medication during school hours.

I/We also assume all responsibility for any mistake in furnishing an incorrect dosage of prescribed medication.

Date _____

Parent/Guardian Signature _____
Phone No. _____ This should be a phone number where parent or guardian can be reached in case there is a question or problem.