Holy Ghost Catholic School

507 N. Oak Street / Hammond, LA 70401-2527

Loving, Learning, and Living in Christ

PARENTAL CONSENT FOR MEDICATION ADMINISTRATION

Please give my child, _____, (Name of Child)

the medication as ordered below by Dr._____.

I accept the rules of the school concerning the giving of medication, including the following:

1) The medication must be prescribed by a physician, who must also certify in writing that it is **NECESSARY** for the child to receive the medication during school hours. This certification shall be obtained by having the physician complete and sign the form below.

2) The medication must be brought to the school by an adult in a container with label from the pharmacy, showing name of medication, dosage, child's name and the time to be given. Supply must not exceed one months supply. The empty container will be sent home.

3) This school or designated person administering the medication are held harmless for any unintentional mistakes or oversight in keeping or giving my child's medication.

Medication administered at school:

Medication:_____

Time(s):_____

Dosage:_____

Duration:_____

(Parent or Guardian Signature _____)

Parent or Guardian Address_____

Home Telephone #: _____ Work Telephone : _____

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Physician's Order Form To be completed by physician only.

I hereby certify that it is necessary for the medication listed above to be given during school to: _____.

Physician's signature: _____ **Date:**_____ Office telephone #: _____