Holy Apostle School
3875 South 159th Street
New Berlin, WI 53151
262-786-7331

Parent/Guardian Medication Consent Form

Full Name of Child to be medicated: _____

Name of Drug and Dosage: _____

Hour(s) Medication to be given: _____ Number of Days _____

Name of Physician prescribing Medication: _____

Physician's Phone Number _____

I hereby give permission to the Health Room/Office Personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold Holy Apostles School, it's employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.

I would like this medication to go on all Field Trips: yes☐ No ☐

_____ _____
Signature of Parent/Legal Guardian Date

_____
Address

_____ _____
Home Phone Number Work Phone Number

Please return this form and the physician's form completed along with the medication to the school office. Medication should be in the original container from the pharmacy.