ST. FRANCIS HIGH SCHOOL

MEDICATION/MEDICAL RELEASE FORM

St. Francis High School does not have a school nurse. By signing this form you are accepting responsibility for your daughter's use of prescription medication while on campus. It is the responsibility of the student and her parent(s) to know and understand the specific dates, times and dosages of all medications to be taken during school hours.

Student Name _____ Grade _____Date of Birth _____

Address _____

Parent Home phone _____ Cell Phone _____ Work Phone _____

Please list ALL medicines the student is receiving, including those given during the school day.

1._____ 2. _____ 3._____ 4._____

My daughter is known to have the following allergies: _____

Consent

I give permission to have school personnel designated by the administration to monitor my daughter while she self-administers the following medications.

1._____ 2. _____ 3._____ 4._____

prescribed by _____ Phone #_____
Name of Medicine Licensed Prescriber

In the event of an emergency 9-1-1 will be notified. Please note any other care instructions:

_____

_____

_____

_____

I give permission for school administration to share with appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my child's health and safety. (Yes) _____ (No) _____

Start date of medication storage_____ End date of medication storage_____

I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following the end date of medication storage or one week beyond the close of school in each semester.

Parent/Guardian _____
(Please print)

Parent/Guardian _____
(Signature)

Relationship to Student _____

Date _____