

**AUTHORIZATION FOR UTILIZATION OF  
MEDICATION AND RELEASE**

Student's Name: \_\_\_\_\_  
(Last) (First) (Sex) (D/O/B) (Grade)

Physician's Name/Address: \_\_\_\_\_

Physician's Telephone Number: \_\_\_\_\_

**The following section is to be completed by the Parent/Guardian:**

I hereby authorize my son/daughter/ward to self administer or have administered to him by designated school personnel, prescription medications as outlined below by my child's physician. My child/ward is currently on the following other medications:

- Other medications: \_\_\_\_\_
- None
- I elect not to disclose the other medications my child/ward presently takes.

It is understood that all medication will be supplied in the original labeled pharmacy container and that only those doses which shall be needed for school administration shall be included. Additionally, it is understood that any prescription medication should be delivered to the school by the student's parent or a responsible adult. No student will be allowed to carry medication in school, without the express authorization of the school nurse, in consultation with the school principal. It is understood that to the extent possible, prescription medication required to be given to a student will be administered at home, either before or after school.

In case of an emergency, I may be reached at my home phone number: \_\_\_\_\_ or at  
\_\_\_\_\_  
(alternative phone number)

In the case of a medication emergency, if I may not be reached, you may contact my child's physician as referenced above.

In addition, in the case of medication emergency, the following individuals may be contacted:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I individually, and as parent/guardian of my child, for ourselves and for our heirs, executors and administrators, hereby release and forever discharge the Roman Catholic Archbishop of Boston, a Corporation Sole, \_\_\_\_\_, its principal, teachers, instructors, volunteers, priests,

(Name of School)

employees and agents and each such persons and such entity's agents, representatives, successors or assigns from and any and all claims and causes of action, including but not limited to claims for personal injury which I,

individually and as parent or guardian of my child, may have arising out of or in any way related to the administration of the medications referenced herein.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Printed Name of Parent/Guardian

Date: \_\_\_\_\_

**The following is to be completed by the student's Physician:**

Diagnosis for which medication is prescribed: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

If medication is to be given **daily**, at what time? \_\_\_\_\_

If medication is to be given "**when needed**", describe indications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_

List significant side effects. \_\_\_\_\_

\_\_\_\_\_

Length of time this treatment is recommended. \_\_\_\_\_

Is child authorized to medicate himself or herself? \_\_\_\_\_

Other information. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

Date: \_\_\_\_\_