

**PHYSICIAN'S STATEMENT REGARDING  
ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL**

**IF POSSIBLE, PLEASE SCHEDULE MEDICATION OUTSIDE OF THE SCHOOL HOURS**

1. Name of student \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Address \_\_\_\_\_ Home Phone \_\_\_\_\_

3. Condition for which medication is to be given \_\_\_\_\_

4. Name of Medication \_\_\_\_\_

5. Method of administration: Oral \_\_\_\_\_ Inhaler \_\_\_\_\_ Injection \_\_\_\_\_ Other \_\_\_\_\_

6. Dose \_\_\_\_\_ Schedule of Doses \_\_\_\_\_

7. The medication is to be continued as above until \_\_\_\_\_

8. Precautions advised \_\_\_\_\_

Possible reactions to medication \_\_\_\_\_

Actions to be taken in case of a reaction to medication \_\_\_\_\_

9. Check one below:

\_\_\_\_\_ I give this student permission to self-administer the above medication.

\_\_\_\_\_ I authorize designated school personnel to administer the above medication.

10. Print name and address of physician,  
or use stamp

Date \_\_\_\_\_

Phone \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

(OVER)

**ONE MEDICATION PER FORM, PLEASE**

**PARENT'S OR GUARDIAN'S REQUEST FOR  
ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL  
AND WAIVER AND RELEASE FROM LIABILITY**

The undersigned hereby request St. Veronica Catholic School Personnel to assist \_\_\_\_\_  
\_\_\_\_\_ in matters set forth on the Physicians Statement.

11. Name of parent or guardian \_\_\_\_\_

12. Phone # where a parent/guardian may be reached during the school day \_\_\_\_\_

I will notify the Principal of the school immediately if there is a change in my child's medication schedule or if the physician prescribing the medication is no longer providing health care for my child.

I understand it is my responsibility to send the medication to school in the original pharmacy container including my child's name and the doctor's instruction.

Check below:

\_\_\_\_\_ I give \_\_\_\_\_ permission to self-administer the above referenced medication.

\_\_\_\_\_ I authorize designated school personnel to administer this medication.

I understand that St. Veronica Catholic School reserves the right to discontinue its involvement in the above referenced administration of medicine.

School personnel will not administer injections. Should an injection appear to be necessary, the school will contact parents/guardians first then other people listed on the family emergency list. Should no one be available, the student will be taken to the nearest emergency hospital at the expense of the parents. (Due to the immediate seriousness for a severe allergic reaction, an EpiPen injection will be given by school personnel if necessary.)

I UNDERSTAND THAT ST. VERONICA CATHOLIC SCHOOL IS NOT LEGALLY OBLIGATED TO STORE OR ADMINISTER MEDICATION FOR STUDENTS. THEREFORE, IN CONSIDERATION FOR THE ABOVE REFERENCED ARRANGEMENTS, THE UNDEERSIGNED DOES HEREBY RELEASE AND DISCHARGE THE ARCHDIOCESE OF SAN FRANCISCO, IT'S CONSTITUENT ORGANIZATIONS, INCLUDING, BUT NOT LIMITED TO ST. VERONICA CATHOLIC PARISH/SCHOOL AND THEIR OFFICIERS, AGENTS AND EMPLOYEES, FROM ANY AND ALL CLAIMS FOR PERSONAL INJURUES OR PROPERTY DAMAGE THAT I OR MY CHILD MAY SUFFER AS A RESULT OF THIS ARRANGEMENT WHETHER OR NOT SUCH INJURIES OR DAMAGE ARE CAUSED BY THE NEGLIGENCE (WHETHER ACTIVE OR PASSIVE) OF ANY OF THE ENTITIES OR INDIVIDUALS NAMED OR DESCRIBED ABOVE.

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

**ONE MEDICATION PER FORM, PLEASE**