



Blessed Sacrament School

748 W. Laurel ~ Springfield, IL 62704
522-7534 (phone) ~ 522-7542 (fax)

PARENTAL REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL AND RELEASE FROM LIABILITY

(This form MUST be returned to school when child returns with medication.)

I/We, the undersigned parents/guardian of the minor child, _____,
a student at Blessed Sacrament School, hereby request Blessed Sacrament School to allow said child
to attend school in spite of his/her special health problems and to be given medications prescribed by
_____ from _____ to _____
(physician) (date) (date)
under the supervision of school personnel. The medicine is to be provided by me and be labeled by the
physician or pharmacist with said child's name, doctor's name, drug store, name of drug, and the specific
time that it is to be given at school. I/We assume all responsibility for any mistake in furnishing an
incorrect dosage. For and in consideration of allowing said child to attend school in spite of his/her special
problem, I/we hereby release, relieve and discharge Blessed Sacrament School and/or any of its agents or
employees, from any and all liability for any injury or damage to the health of said child arising out of, or
resulting from the necessity of said child having to take medication during school hours.

I/We have read, understand and agree to the school's regulations concerning giving medication at school.

Parent/guardian signature _____ Date _____

Address _____ Phone _____



STATEMENT OF PHYSICIAN

Name of student Child's Date of Birth Diagnosis

Name of Medication Dosage Route of Administration

Frequency Intended Effect of
Medication Time

Predictable Side Effects Contraindications

Other medications student is receiving _____

Physician's Signature Physician's Phone Date

Physician's Address _____

All medications will be kept in a locked drawer. The principal will administer or designate an appropriate person to administer the medication.