# Administration of Medication Consent

Note: Return completed form to the campus office.

School FAX: _____

One form for each medication given at school.

New forms required for changes in medications, dosage or time of administration.

**ALL MEDICATIONS ADMINISTERED BY XCS STAFF are only available during school hours.**

Student Name: _____ DOB: _____

Xavier Campus: _____ Grade/Teacher: _____

Medication Name/Strength:_____ ☐ Prescribed* ☐ Non-Prescribed

Dosage: _____ How Given: _____ Time to be Given: _____

Effective Dates: ☐ School Year _____ OR Specific Dates: ☐ _____ to _____

Reason for Medication:

_____

_____

_____

If "as needed", list conditions under which medication should be given:

_____

_____

Possible Side Effects: _____

*Prescribing Practitioner's Name: _____ Phone: _____Fax: _____

*Prescribing Practitioner's Signature: _____

*I hereby give my permission to school personnel to give this medication to my child according to the directions stated above and to contact the child's physician if necessary. I further agree to hold St. Francis Xavier Catholic School System and above person harmless in any and all claims arising from the administration of this medication at school. I agree to notify the school in writing when any change in the above order is necessary.*

Parent/Guardian's Signature: _____ Date: _____

Contact Day Phone: _____ Contact Cell Phone: _____

*I agree to allow my child to transport the medication container (filled or empty) to and from school for the purpose maintain medication needed at school for administration.* ☐ *YES* ☐ *NO*