Bishop Kenny High School, Inc.

Parent Permission for the Administration of PRESCRIPTION MEDICATION

Student_____ D.O.B_____

Name of Medication_____

Prescribing Doctor_____ Prescription Number_____

Date of Prescription _____ Quantity _____

I, _____, grant permission for the principal or
(Parent or legal guardian)

the principal's designee to assist in the administration of the prescribed medication

for my child/legal ward, _____.
(Students Name)

I certify that the prescribed medication is in its original container and that it is necessary, according to my child/legal ward doctor's instructions, for this medication to be provided during the school day. I understand that this medication will be given only according to the directions on the label as prescribed by the physician. Further, I agree to waive any claims of liability that may arise against any/all school, church or diocese personnel, relative to the administration of this medication to my child/legal ward according to these directions. I further understand that no later than the end of the school year any unused medication must be picked up or it will be destroyed.

_____ _____

Date **Signature of parent/legal guardian**