St. Patrick's Episcopal Day School
4700 Whitehaven Parkway, NW
Washington, DC 20007

Permission for Administration of Prescription Medication

I give my permission for the school nurse to administer the following prescribed medication if needed to my child. I release St. Patrick's Episcopal Day School and any of its employees from liability in the event of an adverse reaction, injury, illness, or death arising from administering this medication. I understand that the school nurse will not administer the first dose of any medication.

Name: _____ Class: _____

Physician: _____ Office number: _____

Medication: _____

Administration reason: _____

Dose: _____ Administration times: _____

Dates to be administered: _____

Parent Signature: _____ Date: _____

Medication must be in the original pharmacist labeled container with the following information:

1. **Child's full name**
2. **Name of medication**
3. **Dosage**
4. **Frequency**
5. **Physician's name**
6. **Date dispensed**
7. **Expiration date**
8. **Additional instructions (i.e., with meals, water) if necessary.**