

**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/Guardian and Healthcare Provider signatures required**

→ Parent Signature: _____ Date: _____

→ Physician 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.**