MEDICATION PERMISSION FORM
Incarnate Word Academy
2026-2027 School Year

Student_____ D.O.B._____

School _____Grade_____

Policy for students receiving medication at school, whether prescribed medication or over-the-counter medication approved by a physician, is as follows:

- Signed orders from the parent/guardian and physician must be on file.
- Prescribed medication with a pharmacy label that matches the written orders and is in the original container.
- All medication must be provided to the school by the parent/guardian.
- School personnel will review TCCB ED and Archdiocesan guidelines to ensure medication may be administered.
- A completed Medication Permission Form is approved for one academic school year.

To be completed by the Parent/ Guardian

Does the parent want to be called before a PRN "as needed" medication is given? ❑ Yes ❑ No

Parental/Guardian Consent

I hereby request that the medication specified by the prescribing physician/healthcare provider be given to the above-named student. I understand that the school personnel who give the medication may not be medically trained persons. I realize that Incarnate Word Academy does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreement to allow the medication to be given is for my benefit and the student's benefit, and such an agreement by the school gives adequate consideration of my agreements contained herein.

In consideration for Incarnate Word Academy agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless Incarnate Word Academy, the Congregation of the Incarnate Word and Blessed Sacrament, and their servants, agents, directors, officers, and employees—including, but not limited to, the principal/head of school and the individuals giving the medication—of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent/guardian of the student, hereby release and waive all claims, demands, or causes of action against Incarnate Word Academy, the Congregation of the Incarnate Word and Blessed Sacrament, and their agents, servants, or employees—including, but not limited to, the principal/head of school and the individual giving or failing to give the medication.

Parent/ Guardian Signature _____Date _____

****Other forms are required for severe allergies, diabetes, asthma, seizures, and other health conditions. self-carry medication, and self-administration**

To be completed by the Physician:

Type of Medication ❑ Prescription ❑ Non-Prescription		Name of Medication and Strength	
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
For **PRN** state the Frequency (time between dosages of medication and maximum number in a school day			
Reason medication being given			
Form of Medication ❑ Tablet ❑ Capsule ❑ Liquid ❑ Inhalant ❑ Injection ❑ Other _____			Route (ex: oral, nasal)
Physician's Signature	Physician's Printed Name	Office Phone	Date

For additional medications use the back page.

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