Saint Alban Roe Catholic School
2005 Shepard Road
Wildwood, MO 63038

# PHYSICIAN CONSENT FOR MEDICATION ADMINISTRATION

**Please return to nurse@stalbanroe.org or Fax 636.405.3026**

---

*(To be completed by the physician prescribing the medication.)*

**Date:** _____ **Name of Student:** _____

**Name of Medication:** _____

**Dose:** _____ **Time Interval:** _____

**Diagnosis or reason for treatment:**

_____
_____
_____

**Side effects to look for:**

_____
_____
_____

**Restrictions:** _____
_____
_____

**Physician Name (print):** _____

**Physician Signature:** _____

**Phone Number:** _____

**Saint Alban Roe Catholic School**
**2005 Shepard Road**
**Wildwood, MO 63038**

# PARENTAL CONSENT FOR MEDICAL ADMINISTRATION TO THEIR CHILD

**Please return to: nurse@stalbanroe.org**
**Or**
**Fax: 636-405-3026**

---

**Date:** _____ **School: St. Alban Roe Catholic School**

**Name of Student:** _____

**Grade:** _____ **Teacher:** _____

- ***My child is to receive the following medication according to the directions given: Name of medication:*** _____
- ***This treatment will last for (give duration):*** _____
- ***My child has the following drug allergies:***

_____

_____

_____

*I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.*

*I understand and acknowledge that any medication administered to my child during school may not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.*

**Name of Parent (Print):** _____

**Signature of Parent:** _____

**Date:** _____