## PHYSICIAN'S STATEMENT REGARDING
## ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

*IF POSSIBLE, PLEASE SCHEDULE MEDICATION OUTSIDE OF THE SCHOOL HOURS*

1. Name of Pupil _________________________ Date of Birth___________________
2. Address ____________________________________ Telephone______________________
3. Condition for which medication is to be given:____________________________________________

   ________________________________________________________________________________
4. Name of Medication:_____________________________________________________________
5. Method of administration: Oral ___ Inhalator ___ Injection___ Other___
6. Dose:____________________ Schedule of doses:___________________________
7. The medication is to be continued as above until __________________________________________
8. Precautions advised:_______________________________________________________________

   Possible reactions to medication: _______________________________________________________

   Actions to be taken in case of reaction to medication:_______________________________________
9. Check one below:

   _____ I give this pupil permission to self-administer the above medication.

   _____ I authorize designated school personnel to administer the above medication.
10. Print name and address of physician or use stamp: Date:__________________________

    ______________________________________ Phone:__________________________

    _____________________________________

    _____________________________________

    _____________________________________ ______________________________

    Signature of Physician

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### PARENT'S OR GUARDIAN'S REQUEST FOR
### ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL
### AND WAIVER AND RELEASE FROM LIABILITY

The undersigned hereby requests St. Gabriel School to assist ________________________in the matters set forth in the above Physician's statement.

Name of parent or guardian:_________________________________________________________________

Telephone where a parent/guardian can be reached during the school day: ____________________________

Language(s) used at home: __________________________________________________________________

**Over**

*I will notify the Principal of the school immediately if there is a change in my child's medication schedule or if the physician prescribing the medication is no longer providing health care for my child.*

*I understand it is my responsibility to send the medication to school in the original pharmacy container including the child's name and doctor's instructions.*

*Check one below:*

____ *I give ______________________________ permission to self-administer the above referenced medication.*

____ *I authorize designated school personnel to administer this medication..*

*I understand that St. Gabriel School reserves the right to discontinue its involvement in the above referenced administration of medicine.*

*I UNDERSTAND THAT ST. GABRIEL SCHOOL IS NOT LEGALLY OBLIGATED TO STORE OR ADMINISTER MEDICATION FOR STUDENTS. THEREFORE, IN CONSIDERATION FOR THE ABOVE REFERENCED ARRANGEMENTS, THE UNDERSIGNED DOES HEREBY RELEASE AND DISCHARGE THE ARCHDIOCESE OF SAN FRANCISCO, ITS CONSTITUENT ORGANIZATIONS, INCLUDING, BUT NOT LIMITED TO ST. GABRIEL PARISH/SCHOOL AND THEIR OFFICERS, AGENTS AND EMPLOYEES, FROM ANY AND ALL CLAIMS FOR PERSONAL INJURIES OR PROPERTY DAMAGE THAT I OR MY CHILD MAY SUFFER AS A RESULT OF THIS ARRANGEMENT WHETHER OR NOT SUCH INJURIES OR DAMAGE ARE CAUSED BY THE NEGLIGENCE (WHETHER ACTIVE OR PASSIVE) OF ANY OF THE ENTITIES OR INDIVIDUALS NAMED OR DESCRIBED ABOVE.*

________________________________________ ____________________________

*Signature of Parent or Guardian* *Date*

***ONE MEDICATION PER FORM, PLEASE***

***Return completed form to the Principal.***