



**St. Augustine**

CATHOLIC SCHOOL

A NOTRE DAME ACE ACADEMY

**PARENT'S REQUEST FOR THE ADMINISTRATION OF  
MEDICATION BY SCHOOL PERSONNEL  
2023-2024 SCHOOL YEAR**

I hereby request, authorize and give my permission to the principal or his/her designee, (e.g., school nurse or responsible person) to administer the following medication (provided to the school for my student) to my child.

Prescribed medication:

\_\_\_\_\_  
(See Physician's completed request form attached if Rx)

Non-prescription medication:

\_\_\_\_\_  
(Over the counter)

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Name of prescribed drug, dosage and route of administration

\_\_\_\_\_  
Time of day to be administered

Beginning and expiration date of this request:

\_\_\_\_\_  
It is not possible for this medication to be taken at home by my son/daughter, and it must be administered during the school day. I have provided the medication in its original packaging to the school clinic for administration to my child.

In consideration of my child being administered the above specified medication at my request, on behalf of my child, my spouse, and myself. I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, St. Augustine School, St. Augustine Parish, employees and volunteers from all claims, judgments, and liability for any injury or damage due to the designated administration of said medication to my son/daughter.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date