

PARENT REQUEST FOR ST. ALBERT THE GREAT SCHOOL TO ADMINISTER MEDICATION REGULARLY THROUGHOUT THE SCHOOL YEAR

Child's Name _____ Grade _____

To St. Albert the Great Personnel: I request that school personnel administer to my child, named above, the following medication:

Name of medication _____

Prescribed by Dr. _____ Beginning Date _____ until _____

Dosage to be given at school _____

Special instructions about medication or administration of it _____

I understand that this medication must be brought to the designated office at the school and that I will pick up the medication after its usage. (Medicines that are not picked up two weeks after the child's last dosage will be discarded). I understand that the medication must be in its original container with the dosage correctly labeled and that school personnel will not administer any medication where the dosage is not indicated on the medication container. I understand that it is my responsibility to see that the medication is refilled as needed.

I understand that the school is not a medical facility and that there is not a trained, licensed medical person available to administer medical treatment. I understand that medical assistance other than what is outlined above will require the parent to come to school or emergency medical help (EMS) to be called.

In consideration for the assistance the undersigned parent/guardian for himself/herself, the child and any persons legally related to said child, shall hold harmless and indemnify the Archdiocese of Louisville, St. Albert the Great Catholic Church, St. Albert the Great School, the employees, agents, staff, volunteers, and teachers, for any and all liability, claims, demands, damages, expenses, and attorney's fees arising out of the giving, failure to give and improper giving of the aforesaid medication.

Printed name of parent _____

Signature of parent _____ Date _____

Phone number of this parent during the day _____