

ARCHDIOCESE OF MILWAUKEE

PARENT/GUARDIAN PRESCRIPTION MEDICATION CONSENT FORM

Name of School: Catholic Central High School
Address of School: 148 McHenry St., Burlington, WI 53105
Telephone # of School: 262-763-1510 Fax # of School: 262-763-1509

Full name of student to be medicated: _____

Name of drug and dosage: _____

Hour(s) medication to be given: _____ # of days _____

Name of physician prescribing medication: _____

Physician's phone number: _____

I hereby give permission to the Health Room/Office Personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the above named school, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.

Signature of Parent/Legal Guardian

Date

Address

Home phone #

Work phone #

Please return this form completed along with the medication(s) to the school office.