

St. Boniface Catholic School
Medicine Administration Authorization

I request that you give medication to my child during the school day. The medication is in the original container and the container has the child's name on it.

I will not hold the school staff responsible for any undesired reaction that may occur from the medication. I understand that a designated responsible adult or I will pick up any unused medication from the school office within one week of the last dose or the remaining medication will be discarded.

Student's
Name _____ Grade _____ Teacher _____

Medication _____ Dosage _____

Time(s) to be given _____ Date(s) _____

Medication will treat (ailment) _____

Name of physician _____

Parent/Guardian signature _____ Date _____

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