SAINT PATRICK PARISH

THE CATHOLIC COMMUNITY OF HUDSON, WISCONSIN

FAITH FORMATION

PERMISSION TO ADMINISTER MEDICATION

This form must be returned to Saint Patrick Faith Formation Office. A physician's order is necessary for over-the-counter or prescription, short-term, and long-term medications. We cannot and will not administer any medication without it.

The following information must be completed by the parents:

Student's Name _____ Birth Date: _____

Address _____ Home Phone: (_____)_____

Emergency Phone Numbers: _____

Class Information: Grade: _____ Day: _____ Time: _____

Instructor's Name: _____

Other medications the child is taking: _____

I hereby confirm my primary responsibility to administer medications to my child. However, in the event that I am unable to do so, I hereby authorize Saint Patrick Faith Formation Office and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child (or allow my child to self administer, while under the supervision of the employees or agents of Saint Patrick Parish) Lawfully prescribed medication in the manner described below. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY CHILD TO BE PREFORMED BY AN INDIVIDUAL OTHER THAN A NURSE OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed is so administered or attempted to be administered, I waive any claims I might have against Saint Patrick Faith Formation, its employees and agents Saint Patrick Parish and the Catholic Diocese of Superior, arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Saint Patrick Faith Formation, its employees and agents, Saint Patrick Parish and the Catholic Diocese of Superior, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent Signature: _____ Date: _____

Important Information About Medications

The medication is to be brought to the Faith Formation Office in its original pharmaceutical container, clearly marked with the child's name, the medication name, and pertinent information. Duplicate prescription bottle can be obtained from your pharmacist. Over-the-counter medication shall be brought in its original, unopened container with the seal unbroken. We will not administer any medication sent to Faith Formation Office in Tupperware, baggies, envelopes, etc.

The parents must report immediately any change in prescription or dosage. New permission forms must be obtained for each charge.

The Permission to Administer Medication Form will be kept in the Faith Formation Office.

MAIL: 403 St. Croix Street; Hudson, WI 54016 VOICE: 715.386.9209 FAX: 715.386.0462

The following information must be completed by the physician:

Physician's Name: _____ Phone: (_____)_____

Physician's Address: _____

Patient Name: _____ Date of Birth: _____

Name of Medication_____Dosage_____

Route of Administration_____Frequency_____Times_____

Intended Effect of Medication_____

Possible Side Effects_____

Additional Instruction/Comments_____
_____

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Possible Side Effects_____

Additional Instruction/Comments_____
_____

The above medication as prescribed is necessary for this child to receive during their Faith Formation session in order to maintain an optimal state of health.

Physician's Signature_____ Date_____