ST. THOMAS THE APOSTLE CATHOLIC SCHOOL

LEARN ▪ LEAD ▪ LOVE

DIOCESE OF LANSING
WAIVER OF LIABILITY

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

SCHOOL YEAR _____

DATE _____

NAME OF STUDENT _____

MEDICATION TO BE ADMINISTERED _____

Dosage _____ Frequency _____ Time of Day _____

This authorization expires _____

Physician's Name _____ Telephone Number _____

Physician's Signature _____
(*required for all prescription medications*)

I understand and agree that this medication will be administered to my child under the supervision of authorized personnel such as the secretary, principal, or teacher. I hereby waive any claim against St. Thomas School, the Diocese of Lansing and its employees on account of the distribution of this medicine. I further agree that you may contact the physician who prescribed the medication.

_____
Parent Signature

_____
Parent Signature