

WAVE OF LIABILITY

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

St. John School –Fenton
Diocese of Lansing

Date _____ Birthdate _____

Name of Student _____ Grade _____

Medication to be Administered _____

Dosage _____

Frequency _____ Time of Day _____
(Daily, Hourly, etc.)

The Authorization Expires _____

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. John 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 medicine and I hereby authorize him/her to release to you any and all information regarding my child's condition, treatment, history, prognosis or any other facts in his possession concerning the child.

Parent/Guardian Signature