



Authorization to Administer Medication

Parents/guardians are requested to be present to administer any necessary medication to their children whenever possible. If a parent/legal guardian of the child is unable to be present to administer any necessary medication, only an on-duty, trained medication distributor may administer the medication. The trained medication distributor may only administer medication pursuant to this Authorization.

Written instructions from the Child's physician must be provided, and must state the following:

1. The child's name;
2. The name of the medication;
3. The proper dosage of the medication;
4. The purpose of the medication;
5. The time of day/circumstances in which the medication is to be administered;
6. The anticipated number of days the medication must be administered; and
7. Any possible side effects of the medication

Any medication must be brought in a container appropriately labeled by a pharmacy or the child's physician.

If a child has a condition that might require medication of an emergency basis (e.g., in the case of a child's allergic reaction, asthma attack, etc.), the child's parent or legal guardian must provide all necessary information and training or instruction to the on-duty, trained medication distributor.

I certify that the above conditions have been met in their entirety.

I hereby authorize any on-duty, trained medication distributor to administer medication to my child according to the written instructions of the child's physician.

I RELEASE HOLY FAMILY HIGH SCHOOL AND THE ARCHDIOCESE OF DENVER FROM LIABILITY FOR ANY ADVERSE REACTION SUFFERED BY MY CHILD AS A RESULT OF THE ADMINISTRATION OF MEDICATION TO MY CHILD IN ACCORDANCE WITH THE WRITTEN INSTRUCTION OF THE CHILD'S PHYSICIAN. I AGREE TO INDEMNIFY HOLY FAMILY HIGH SCHOOL AND THE ARCHDIOCESE OF DENVER OF ANY MEDICAL EXPENSES, LEGAL EXPENSES, OR LIABILITY RELATED TO ANY ADVERSE REACTION SUFFERED BY MY CHILD AS A RESULT OF THE ADMINISTRATION OF MEDICATION TO MY CHILD IN ACCORDANCE WITH THE WRITTEN INSTRUCTION OF THE CHILD'S PHYSICIAN.

I have carefully read this Authorization to Administer Medication, and I understand and agree to each of the covenants and conditions set forth above. This Authorization to Administer Medication is effective for _____ (state the relevant time period, such as one day or one week, up to one year for chronic conditions), unless earlier revoked.

Dated this _____ **day of** _____, _____

Parent or Legal Guardian

Child's Name and Birth Date: _____

Name/Address/Telephone of parent(s) or guardian(s): _____
