

Diocese of San Jose – Holy Family School  
Physician's Statement Regarding  
Administration of Medicine by School Personnel  
And  
Waiver and Release from Liability

**Physician Signature Required**

**DIRECTIONS:** Please schedule medication outside of school hours whenever possible. This form **must** be on file before school personnel may administer medication to your student. Both sides of form need to be completed. One form per student, please.

1. Name of Pupil \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Address \_\_\_\_\_ Telephone \_\_\_\_\_

3. Condition for which medication is to be given \_\_\_\_\_

4. Name of medication \_\_\_\_\_

5. Method of administration: Oral \_\_\_ Inhaler \_\_\_ Injection \_\_\_ Other \_\_\_

6. Dose \_\_\_\_\_ Schedule of doses \_\_\_\_\_

7. The medication is to be continued as above until \_\_\_\_\_

8. Precautions advised \_\_\_\_\_

Possible reactions to medication \_\_\_\_\_

Actions to be take in case of reaction to medication \_\_\_\_\_

\_\_\_\_\_

9. \_\_\_ I authorize designated school personnel to administer the above medication

10. Print the name and address of physician \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***Signature of Physician***

***ONE MEDICATION PER FORM – PLEASE COMPLETE REVERSE.***

Diocese of San Jose – Holy Family School  
Parent's or Guardian's Request for  
Administration of Medicine by School Personnel  
And  
Waiver and Release from Liability

The undersigned hereby requests Holy Family School to assist \_\_\_\_\_  
in the matters set forth on the reverse side of this form, Physician's Statement.

11. Name of parent or guardian \_\_\_\_\_

12. Telephone where a parent/guardian can be reached during the school day \_\_\_\_\_

13. Language(s) used at home \_\_\_\_\_

I will notify the Principal of the school immediately if there is a change in my child's medication schedule or if the physical prescribing the medication is not longer providing health care for my child.

I understand it is my responsibility to send the medication to school in the original pharmacy container including the child's name and the doctor's instructions.

\_\_\_\_\_ I authorize designated school personnel to administer this medication.

I understand that Holy Family School reserved the right to discontinue its involvement in the above referenced administration of medicine.

*I understand that Holy Family School is not legally obligated to store or administer medication for students. Therefore, in consideration for the above referenced arrangement, the undersigned does hereby release and discharge the Diocese of San Jose, its constituent organizations, including, but not limited to Holy Family School for personal injuries or property damage that I or my child may suffer as a result of this arrangement whether or not such injuries or damage are caused by the negligence (whether active or passive) of any of the entities or individuals named or described above.*

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

Date \_\_\_\_\_

Date \_\_\_\_\_

(If more than one parent/guardian, both should sign.)

**ONE MEDICATION PER FORM – PLEASE COMPLETE REVERSE.  
Physician Signature Required**