

**PARENTAL CONSENT TO DISPENSE MEDICATION**

This form must be completed for any/all prescription or over the counter medications. This includes: cough drops, any form of skin lotion, Tylenol, Tums, inhalers, etc. Students may not carry medication with them while on school property. All medications must be kept in a locked cabinet in the school office. The only exception to this policy is an inhaler for the treatment of asthma. The student may carry the inhaler with them for use as necessary. A medication authorization must be kept on file in the office for inhalers. Any/All medications sent to the school must be in their original packaging.

My permission is granted to St. Thomas Aquinas School to assist the following student \_\_\_\_\_ in taking medication as described below:

(Student Name)

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Name of **Prescription Drug**: \_\_\_\_\_

Amount to be dispensed: \_\_\_\_\_

Time or times of day to be given: \_\_\_\_\_

Date to begin: \_\_\_\_\_ Date to end: \_\_\_\_\_

Name of prescribing Physician: \_\_\_\_\_

Briefly explain the purpose for the medication: \_\_\_\_\_

\_\_\_\_\_

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Name of **Over the Counter Drug**: \_\_\_\_\_

Amount to be dispensed: \_\_\_\_\_

Time or times of day to be given: \_\_\_\_\_

Date to begin: \_\_\_\_\_ Date to end: \_\_\_\_\_

Briefly explain the purpose for the medication: \_\_\_\_\_

\_\_\_\_\_

It is understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects. **St. Thomas Aquinas School is prohibited from administering any medication without a completed and signed parental consent form.**

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

\_\_\_\_\_  
Date

*For Office Use Only*

*Date received:* \_\_\_\_\_ *Received by:* \_\_\_\_\_