St. Francis of Assisi School Medication Record

Child's	Name		.							
Medica	tion to be	administered _				I	Oosage			
Time to	be given		To begin	on	Authorization expires on					
Physici	an's Signa	ture (if required	d)		Phone					
my chil	d. I hereb	y waive any cla ministration of	aim against S	t. Francis o	s of Assisi School of Assisi, the Dioce agree that you may	ese of Lan	sing, and i	ts employees on		
		nedication will not administer			rom its original comedicine.	ntainer and	d Extended	l School		
Parent	's Signatur	e		Date						
*****	******	******	*****	*****	*******	*****	******	******		
Date	Time	Witnessed b	y Date	Time	Witnessed by	Date	Time	Witnessed by		

Date	Time	Teacher	Date	Time	Teacher	Date	Time	Teacher