St. John Paul II Classical School
Parent/Guardian Medication Consent Form
2025-26

Full name of child to be medicated: _____

Name of medication: _____

Dosage of medication: _____

Hour(s) medication to be given: _____

Number of days: _____

Reason for medication: _____

Physician prescribing medication (if Rx): _____

Physician phone number: _____

Person(s) who will be giving medication during school hours:

SJPII Administrative Assistant

I hereby give permission to the above named persons to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold St. John Paul II Classical School and its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication at school. I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

_____

Signature of Parent/Legal Guardian Date