## XAVIER CATHOLIC SCHOOLS CONSENT TO RECEIVE PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS

STUDENT	GRADE
PHYSICIAN/PRESCRIBER	PHONE
NAME OF MEDICATION	
NAME OF PHARMACY	
DIAGNOSIS	
Please give the above medication:	
AMOUNT	
TIME OF DAY	
STARTING DATE	ENDING DATE
AMOUNT SENT	
from the medication. I further agree that so medication information may be shared with I understand the law provides that there sha medication where the person administering would under the same circumstances and the	all be no liability for damages as a result of the administration of the medication acts as an ordinary reasonably prudent person nat the school district and the school nurse are to incur no liability, jury arising from the administration of medication.
SIGNATURE	
DATE PHONE	E#/
MEDICATION WILL NOT BE GIVEN IF IT I THE CONTAINER BEFORE SENDING IT TO WHEN YOU PICK UP YOUR CHILD'S PRESCRIF	

Xavier Catholic Schools are not responsible for medications not stored in the Health Center