Chaminade-Madonna College Preparatory
500 Chaminade Drive • Hollywood, FL 33021 • (954) 989-5150

PARENT/GUARDIAN PRESCRIBED MEDICATION CONSENT FORM

Full Name of Student to Receive Medication: _____

Name of Drug and Dosage: _____

Hour(s) Medication to be Given: _____ Number of Days: _____

Reason for Medication: _____

Name of Physician Prescribing Medication: _____

Physician's Phone Number: _____

I hereby give permission to the School Clinic personnel to give the medication(s) to my student according to the directions stated above and further authorize them to contact the student's physician. I agree to hold Chaminade-Madonna College Preparatory, its employees, and agents who are acting within the scope of their duties, harmless in any and all claims arising from administration of this 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/Guardian Date

_____
Address

_____ _____ _____
Home Phone Work Phone Cell