



Permission to Administer Medication during School Hours

Student' Name _____

Grade _____

Food Allergies: _____

Other Allergies: _____

In the event my child is exposed to allergies listed above that present a medical concern, St. Johns Grammar School has my permission to administer medication to my child, by following the Plan of Action & Medications outlined below:

Plan of Action: _____

Medication permitted to be administered at school: _____

Other Medications:

St. Johns Grammar School has my permission to administer medication to my child, by following:

1. The Doctor's directions written on the labeled drug container.
2. As directed below by parent / guardian:

Medical concerns: _____

By signing this permission form, I agree to not hold St. Johns Grammar School liable for any ill-effects of these medications.

Signed by Parent / Guardian

Date