

Please print or stamp:

Physician's Name: _____

Address: _____

Phone: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an Epinephrine auto-injector and self-medicate when necessary. If carried on his person, I will be cognizant of the expiration date and renew the injector when needed. I relieve Saint Peter's Prep and its employees of any liability which may result from the administration of the above medication to my child or from self-administration when certified by the physician.

Parent/Guardian Signature

Date

Home Phone

Emergency Phone