Guardian Angels Catholic School

521 East Fourteen Mile Road, Clawson, Michigan 48017
Telephone: (248) 588-5545 Fax: (248) 589-7356
Website: www.gaschool.com

RELEASE FOR DISPENSING OF MEDICATION

TO BE COMPLETED BY PARENT

I give my permission for Guardian Angels Catholic School (Caregiver, Facility) to give or apply the medication

_____ (Specify, prescribed medication/over the counter product), to my child _____ (Child's Name), as follows:

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, If Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

☐ Check here and attach emergency care plan if this release is for a metered dose asthma inhaler which the student will possess and use at his/her own discretion in school or at school activities. The physician and parent/guardian signature below apply to the inhaler possession and use by students as permitted in Public Act 10-Revised School Code.

_____ Doctor Signature

_____ Doctor Name

_____ Date

_____ Doctor's Phone number

We hereby waive any liability to the school of the Archdiocese of Detroit or any of its personnel that might occur as the result of giving said medication in the indicated dosage at the time requested to our minor child.

_____ Parent/Guardian signature

_____ Parent/Guardian name

_____ Date