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ST. MARY'S INSTITUTE

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CONSENT AND RELEASE FORM (Self Directed Medication)

I _____, as a parent or legal guardian
(Name of Parent / Guardian)
of _____, authorize the designation of
(Name of Student)
specified school personnel of _____, who are not
(Name of School)
licensed health care professionals, to supervise the administration of required
medication, which is to be self-directed to my child.

Type of Medication: _____

Dosage and Frequency of Administration: _____

Beginning Date: _____ Ending Date: _____

I understand every effort will be made to notify me immediately should it become necessary to obtain emergency medical treatment in connection with my child's condition. The person(s) who should be notified and the telephone number(s) are:

Name: _____ Telephone number: _____

Name: _____ Telephone number: _____

In consideration of the acceptance of this authorization for the designation of the assistance for my child, I hereby, for myself, my heirs, executors, administrators and assigns, waive and release any and all claims for damages I may have against said school, their representatives, employees, successors, and assigns, rising out of any and all injuries sustained.

Date: _____

Signature: _____
(Parent / Legal Guardian)

