ST. ROSE SCHOOL DISTRICT #14 –15
18004 ST. ROSE ROAD
ST. ROSE, ILLINOIS 62230
(618)526-7484

ST. ROSE SCHOOL POLICY ON DISPENSING OF PRESCRIPTION MEDICINE

Name of Student _____Grade_____

Name of Parent of Guardian_____

RELEASE OF RESPONSIBILITY

We, the parents or guardians of the above named student, request that personnel of St. Rose School District administer the prescription medicine named below to the above named student.

We also agree to relieve the St. Rose School District and any other school personnel of any responsibility due to the dispensing of the medicine.

NAME OF MEDICATION_____

DOSAGE_____

NUMBER OF DAYS/DATES TO DISPENSE_____

NAME OF DOCTOR_____

_____ _____
Signature of Parent of Guardian Date

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