St Gabriel the Archangel
2019-2020
Parental Consent for Cough Drop Administration at School

Student Name:_____ DOB:_____

My child is allergic to:_____ Homeroom:_____

My child may have a cough drop every 2 hours as needed during the school day.

<u>Parents must provide the cough drops.</u>

By signing this form, I give my permission for cough drops to be administered to my child for the 2019-2020 school year. The school has my permission to contact me with any questions.

I understand and acknowledge that the cough drop may be administered to my child during school by a Registered Nurse or other non-medical school staff. In consideration of the school administering the cough drop to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representatives, from liability that may arise from administering cough drops to my child.

Parent/Guardian Name(print):_____ Date:_____

Signature:_____

Home phone:_____ Cell Phone:_____

Email address:_____

Please turn in this completed form and cough drops to the School Nurse for review.

Teachers - I have reviewed the consent form. Please keep these cough drops and this form in a secure place in your classroom. Use the back of this consent form to record when a cough drop is given. *I will collect all consent forms and remaining cough drops prior to the end of the year.*

_____ _____

School Nurse Signature *Date*

2019-2020 Cough Drop Administration Record

Student Name:_____

Date:	Time:	Time:	Time:	Time:

_____ _____

Teacher's Name Teacher's Signature