

**DISPENSING OF MEDICATION: RELEASE FORM**

We, the undersigned parent and/or guardian of

\_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Student's Name) Mo Day Year

do hereby sign and execute this release on behalf of us and on behalf of our minor son/ daughter/ward.

We enter into this agreement expressly to release, discharge, forgive, and waive any right whatsoever that may accrue to ourselves or to our minor son/daughter/ward, against the school or the Diocese of Saginaw or any personnel of the aforementioned from any liability whatever in the administration of the following medication to:

\_\_\_\_\_ (Student's Name) \_\_\_\_\_ (Grade)

Name of medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Duration: \_\_\_\_\_

- Check here 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 signatures below apply to the inhaler possession and use by students as permitted in Public Act 10 – Revised School Code.

\_\_\_\_\_ (Doctor's Signature) \_\_\_\_\_ (Doctor's Printed Name) \_\_\_\_\_ (Doctor's Phone)

We hereby waive any liability whatever to the school or the Diocese of Saginaw, 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 son/daughter/ward.

Parent's Signature: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PLEASE RETURN COMPLETED FORM WITH DOCTOR'S SIGNATURE TO YOUR CHILD'S BUILDING SECRETARY OR YOU MAY FORWARD IT TO SACRED HEART ACADEMY AT:

FOR GRADES KP – 6  
200 S. FRANKLIN, MT. PLEASANT, MI 48858  
[ELE@SHA.NET](mailto:ELE@SHA.NET)  
PH: 989-773-9530 | FAX: 989-772-9056

FOR GRADES 7-12  
316 E. MICHIGAN, MT PLEASANT, MI 48858  
[HS@SHA.NET](mailto:HS@SHA.NET)  
PH: 989-772-1457 | FAX: 989-772-9056