

Office of Evangelization, Catechesis and Family Life
Roman Catholic Diocese of Albany

SELF-DIRECTED MEDICATION PERMISSION FORM

I, _____, the parent or legal guardian of _____
(Name of child/youth)

authorize the designation of specified parish personnel of _____ Parish who are not 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 that 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 _____ Phone _____

Name _____ Phone _____

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 parish, their representatives, employees, successors and assigns, rising out of any and all injured sustained.

Date ____/____/____

Signature _____
(Parent/Legal Guardian)

10/1/08