Archbishop Bergan Catholic School
545 East 4th Street
Fremont, NE 68025

Medication Permit

As the parent/guardian of ______________________________ ________
Name Age

__________ ______________________________ ________
Date School Grade

I hereby authorize designated school personnel to administer medication to my child. In addition, I give the school administration permission to contact the prescriber as needed and to share medication information with appropriate school personnel. I understand that unlicensed staff may be assigned to provide medication to my student and I accept ultimate responsibility for monitoring the effects of this medication.

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Signature of Parent or Guardian

Special instructions:
Name of medication: ______________________________

Dosage: ______________________________

Time to be given: ______________________________

Date to be given: ______________________________

Has student experienced any side effects from this medication? __________

If yes, please explain: ______________________________

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