

**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