PARENT RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Student _____ Grade _____

School _____ Home Room Teacher _____

Principal or Designee _____

We (I), the undersigned, who are the [circle one–] parent(s), foster parent(s), guardian(s), of the above named student, request that medication be administered to our child in accordance with the instructions of our physician, Dr. _____ (see instructions on reverse side of this form).

We (I) understand that such medication will be brought to school in the original container from the pharmacist or prescribing physician.

We (I) further understand that the administration of said medication is to be done under the supervision of a member of the school staff. We (I) understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

We (I) agree to notify the school immediately if any of the information provided by the physician changes, or if we (I) change physicians or medication or terminate the use of this medication for any reason.

The above-named principal or principal's designee is hereby authorized to discuss with the above named physician conditions for administering the medication and any and all changes.

Signature of Parent/Guardian _____

Address of Parent/Guardian _____
St./Rd. City Zip Code

Home Telephone Number _____ Business/Office Telephone Number _____

Date of Signature _____

(Page two, top section, is to be completed by the family's physician.)

[Physician's Request for the Administration of Medication at School]

Since medication for the students listed below cannot be scheduled for other than school hours, and the administration of such medication may be supervised by medically untrained personnel, it is requested that the medication as indicated below be administered by school personnel.

1. Name of Student _____

2. Address of Student _____

3. Mediation to be administered (name, quantity, time of day, and special instructions including sterile conditions and storage):

_____

_____

_____

4. Severe adverse reactions that, if they occur, should be reported to _____ physician, at _____.

5. Dates to begin cease medication _____
(date to begin) (date to cease)

6. Date of request _____

7. Physician's signature _____

8. Physician's address _____

9. Physician's telephone number _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Persons authorized to administer medication:

_____

_____

_____

Principal's Signature/Designee _____ Date _____

5/22
11/05