

RELEASE FORM FOR STUDENT TO CARRY MEDICATION ON HIS/HER PERSON

**PART A: TO BE COMPLETED BY THE PHYSICIAN OR DENTIST**

It is my opinion that \_\_\_\_\_ is capable of carrying the following medication on his/her person during school, and on school related trips to/from school.:

Medication: \_\_\_\_\_

Dosage and Method of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_

To be given from \_\_\_\_\_ to \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Relevant Side Effect: \_\_\_\_\_

**PLEASE NOTE:**

This medication may be administered by the school nurse or appropriately trained and certified school staff.

Signature of Physician/Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

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

**PART B: TO BE COMPLETED BY THE PARENT**

I give my permission for my child \_\_\_\_\_ to carry on his/her person the medication ordered by his/her physician/dentist. I understand this medication shall be available in school and on school related trips.

B.1. While he/she is in school, the medication shall be stored in the Health Room or with the teacher, unless otherwise specified by the physician/dentist. I assume responsibility for breakage and student misuse. I give permission for trained school personnel to administer the medication.

Signature of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

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