

**If rectal diazepam, may this medication be administered by unlicensed personnel? Yes or No (Circle One)*

**May this student self-administer this medication if permitted by county policy? Yes or No (Circle One)*

**May this student carry this medication on his/her person if permitted by county policy? Yes or No (Circle One)*

Prescriber's Name (please print) _____ Telephone Number _____

Prescriber's Address _____ Fax Number _____

Prescriber's Signature _____ Date _____

I understand that, whenever possible, all medications should be given at home. I give permission for _____
_____ to take the above medication at school according to county policy. I also understand and agree
that the school nurse may talk with the clinician and his or her staff, as well as school personnel, regarding the student's condition and
administration of this medication and its effects. I further understand that the school, county school board and its employees and
agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration
of medication by the student and agree to indemnify and hold harmless the school, the county board of education and its employees or
guardians and agents against any claims arising from the self-administration of medication.

Parents must transport medication to and from designated personnel at the school. Parent assumes responsibility in "change of
location" of medication according to Putnam County School Policy.

Parent/Guardian signature to approve administration of medication _____

Daytime phone number _____