



## 2010-2011 Authorization for Prescription Medication

**Please complete this form and return it to the Health Clinic.**

Student's name: \_\_\_\_\_ Grade: \_\_\_\_\_

Weight: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage to be given: \_\_\_\_\_

Time(s) medication is to be given: \_\_\_\_\_

Effective dates for this authorization: from: \_\_\_\_\_ to: \_\_\_\_\_

\_\_\_\_\_  
(Print Health Care Provider's Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Health Care Provider's Signature)

\_\_\_\_\_  
Date

**Parental Permission (To be completed by Parent/Guardian). Form is void if not completed.**

I request the designated school personnel or its agents to assist my child in the administration of the above named prescription and non-prescription medications. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that (1) there is no liability on the part of the school, its personnel, or agents, and hereby release and waive any claims or actions against such persons or entity as the result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, or when the medication prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date