NEW RICHMOND EXEMPTED VILLAGE SCHOOL DISTRICT

PARENTAL AUTHORIZATION AND RELEASE/PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENT

Student _____ Phone _____

Address _____

School _____ Classroom/Grade _____

PHYSICIAN'S STATEMENT

It is necessary that the above named student take medicine during school hours/ I will notify the school if the medication dosage or procedure is changed or discontinued.

Medication _____ Dosage _____

Instructions for Administering Medicine _____

_____

Instructions for Storage of Medication _____

Beginning Date _____ Duration _____

Possible Adverse Reactions (Report to Physician) _____

Physician's Name (Print) _____

Physician's Address _____

Physician's Phone Number _____

Physician's Signature _____ Date _____

PHYSICIAN'S STATEMENT

I authorize and request the New Richmond Exempted Village School District, through its designated employees, to administer the above medication to my child as directed by the physician's orders. I will deliver the medication personally to the school employee who will administer it. Medication shall be in the same properly labeled container in which it was dispensed by my physician or pharmacist. I will submit a revised statement by the prescribing physician if any of the information provided by the physician changes. I release the New Richmond Exempted Village School District and all of its representatives and employees from any liability concerning the administration or non-administration of the medication to my child.

Parent/Guardian's Signature _____ Date _____

This form must be completed and returned to the Health Aide's or Principal's Office before any medication can be administered.

School Representative's Signature _____ Date _____