



### MEDICATION ADMINISTRATION RELEASE FORM

I request that you give medication to my child during the school day in accordance with Board policy printed below. You are authorized to delegate this authority to another person if so desired. I will not hold the school staff responsible for any undesired reaction which may occur from the medication.

I agree to pay for ambulance service if used to transport my child from school to the doctor or hospital should he/she have a reaction to the medication.

A CONSENT FORM MUST BE SIGNED BEFORE MEDICATION WILL BE GIVEN AT SCHOOL.  
HANDWRITTEN NOTES ARE NOT ACCEPTABLE.

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_ Time for medication to be given \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

For treatment of following illness \_\_\_\_\_

In case of emergency call \_\_\_\_\_ Phone \_\_\_\_\_

Hospital to be called \_\_\_\_\_ Phone \_\_\_\_\_

Doctor to be called \_\_\_\_\_ Phone \_\_\_\_\_

Please list any allergies to food or medication \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_  
Date