

PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE

TO: _____
(Principal)

(School)

I am the parent with legal custody, the legal guardian, or individual assuming permanent care and custody of _____, a student attending this school. This student requires medication at intervals during the school day.

I hereby give my consent and authorize and request the school principal, or _____ (an employee of the school district designated by the principal, and me) to:

_____ Administer _____, a non-prescription medication that I am hereby supplying you, in accordance with the written instructions of the child's physician that is attached hereto.

_____ Administer _____, a filled prescription medication that I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

_____ Administer _____, a filled prescription medication that I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

_____ Permit the student to retain the medication on the student's person since the medication must be administered at unpredictable intervals throughout the day. A physician's statement that the student is capable of, and has been instructed in the proper method of, self-administration of medication is attached.

I understand that under state law, the board of education, the school district, or the employees of the district shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine I have hereby authorized or from the self-administration of medication by the student.

Dated this _____ day of _____, _____.

(Parent with Legal Custody, Guardian, or Individual Assuming Permanent Care and Custody)

(Address)

WITNESS:

LOG OF THE ADMINISTRATION OF MEDICINE
FOR THE _____ SCHOOL
SCHOOL YEAR _____ - _____

DATE MEDICINE ADMINISTERED	NAME OF STUDENT GIVEN MEDICINE	NAME & TITLE OF PERSON WHO ADMINISTERED MEDICINE	NAME OF MEDICINE	DOSAGE & TIME GIVEN