Garner-Hayfield-Ventura C.S.D.
HEALTH SERVICES

PARENTAL AUTHORIZATION FOR SCHOOL ADMINISTRATION OF MEDICATION

PARENTS: please ask the pharmacist for a second labeled bottle to be kept at school.

Student _____ **Date** _____

Building _____ **Grade** _____

Medication _____ **Prescribed by:** _____

Dosage _____ **Time** _____

Dates: From _____ **To** _____

Diagnosis _____

Side Effects/reactions _____

The following must be approved by the School Nurse:

This medicine is furnished by parent or guardian in the original labeled container, including date, name, strength of the medicine, and directions for use. For over-the-counter medication in the original labeled container, this request must be signed by the parent or guardian to authorize giving the medication during school hours.

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has not previously experienced severe side effects from the medication. I will obtain a written physician's order if the medication is changed or discontinued.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and pick up remaining medication and equipment.

Parent/ Guardian Signature_____ **Date**_____

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