ADMINISTRATION OF MEDICATION
BY THE SCHOOL NURSE
Parent/Guardian Authorization

School Year September 1, 2020-August 31, 2021

(Please Print or Type)

Student's Name_____ Date of Birth:_____ Grade:_____
Last *First*

_____ _____ _____
Physician's Name *Address* *Phone #*

I request that the above named student be administered the medication listed below in accordance with the written orders of Dr. _____

I understand and agree that:

- I will bring the medication to the nurse's office in a pharmacy labeled container.
- This permission is effective for the current school year only.
- I will pick up the medication at the end of the school year or the medication will be destroyed

Medication _____

I acknowledge that the school district shall have no liability for any good faith act or omission consistent with the law which results in any injury arising from the administration of the above designated medication. I shall indemnify and hold harmless the Board of Education, its officers, employees or agents against any and all claims, suits or causes of action arising out of the administration of medication to my son/daughter.

_____ _____
Parent/Guardian Date