PARENT REQUEST FOR MEDICATION ADMINISTRATION
School Board Policy ACBD-E2

Student: _____ Birthdate: _____ Grade: _____
Responsible Staff Person(s): Secretary, classroom teacher, paraprofessionals, and administration.
Known allergies of student: _____

Medication (Name and Prescription Number):_____

Dose: _____ How given (ex: oral): _____

Time/Frequency: _____ Continue until: _____

Possible side effects the medication may have on learning and physical functioning:

_____

_____

Physician: _____

Physician's Address: _____

Physician's Telephone: _____

Parent/Guardian Authorization

I request/consent that this medication be given to my child in the manner specified above. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this medication.
In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the School Board, the individual members thereof, and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to cost and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

Parent/Guardian signature: _____ Date: _____
Phone (H): _____ Phone (W): _____ Phone (C): _____