PERMISSION TO ADMINISTER MEDICATION

_____

(child's name) (grade)

Fort Cherry School District has my permission to administer the medication described below to the above-named child. In making this request, I hereby release Fort Cherry School Board and its employees from any and all liability resulting from the administration of this medication. I further give permission to release the information contained herein to district employees who may be in the care and/or supervision of my child.

_____

(parent/guardian signature) (date)

TO BE COMPLETED BY THE PHYSICIAN

Name of medication: _____

Amount of medication child is to take: _____

Time medication is to be taken: _____

Number of days medication will be given: _____

Diagnosis _____

Possible side-effects _____

Self-administered, non-oral, emergency drugs only (please check applicable statement[s]):

☐ Child is required to carry this medication on his/her person for medical emergency purposes.

☐ Child is qualified and able to self-administer this medication.

_____

(physician signature) (date)

TO BE COMPLETED BY THE SCHOOL NURSE

☐ Child has demonstrated an ability to self-administer this medication.

_____

(school nurse signature) (date)