PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF MEDICATION TO STUDENTS

Name of Student _____

School_____ Grade _____

Medication _____ Dosage _____

Starting Date _____ Ending Date _____

Time of day medication is to be given _____

Other Instructions _____

_____ I hereby request the Hemingford Public School District, or its authorized representative, to administer the above-named medication to my child named above and agree to:

1. Submit this request to the principal or school nurse;
2. Personally ensure that the medication is received by the principal or school nurse administering it in the container in which it was dispensed by the prescribing physician or licensed pharmacist or is in the manufacturer's container;
3. Personally ensure that the container in which the medication is dispensed is marked with the medication name, dosage, interval dosage, and date after which no administration should be given.

OR

_____ I hereby authorize my child to self-administer his/her medication as he/she has shown the competency to do so. I hereby agree to:

1. Submit this request to the principal or school nurse
2. Personally ensure that
    a. the medication is received by the principal or school nurse administering it in the container in which it was dispensed by the prescribing physician or licensed pharmacist or is in the manufacturer's container; or
    b. the medication will be kept in the student's possession but only with prior written permission from the parent and principal.
3. Personally ensure that the container in which the medication is dispensed is marked with the medication name, dosage, interval dosage, and date after which no administration should be given.

Signature of Parent/Guardian _____ Date _____

Home Phone Number _____ Alternate Phone No. _____