Howard-Suamico School District

PARENT REQUEST & AUTHORIZATION TO ADMINISTER MEDICATION

Student's Name: ____

Birthdate: ____

School/Grade: ____

Name of Medication (over the counter or prescription): __________________________

Reason for medication: ____

Dosage of medication (not to exceed written label directions without physician authorization): ____

How often can or should it be given? ____

Is this scheduled medication? _____ OR As needed medication? _____

Start date: _____________________ Stop date: _______________________

A. I will deliver the medication to school in its original or prescription container.

B. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

C. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

____
Parent/Guardian Name - print

____ ___________________
Parent/Guardian Signature Date

____ ___________________
Parent Phone #1 Parent Phone #2