Waiver of Responsibility

Name of the student;_____

D.O.B;_____Grade;_____

Medication (name, dose, way of administration): _____

_____

_____

Time of administration:_____

Medication should be administered

From _____ To_____

Instructions: _____

I _____, hereby give permission to the Health Office Staff at AAS Moscow to administer le medication listed above, prescribed by our Doctor for my daughter/son.

I fully understand the use and the purpose of the medication, the side effects of the medication administered by the AAS Health Office staff for my daughter/son .
I understand that I must supply the school with the prescribed medication in the original container properly labeled and with a copy or the original order from the doctor.

_____

Signature of the parent **Date**

Health Office Staff **Date**