Los Alamos Public Schools
"We prepare confident, life-long learners."

Administration of Medication at School

Administering Medication in Schools Permission Form

Date: ____________________ School: ____

Student ____ ID Number ________________
Last First MI

Birth Date ___/____/____ Gender ☐ Male ☐ Female Grade: ____ Home Room Teacher _______________

Drug Allergies ____

Parent/Guardian: ____
Last First Relationship

Home Phone # ____________________ Cell Phone # ____________________ Work Phone # ____________________

TO BE COMPLETED BY PHYSICIAN:

Best Peak Flow	
Medical Condition necessitating medication:	
Name of Medication	**Possible Side Effects**
Directions for medications	
Option for Medication administration (check one):	
☐	Self-administration (unsupervised) as instructed by ________ physician ________ parent
☐	Supervised administration (supervised by nurse or principal's designee)

____ ________________
Physician's Signature Date

TO BE COMPLETED BY PARENT/GUARDIAN

The medication(s) listed above must be taken during school hours as directed by the physician. I grant permission for the Los Alamos Public Schools to exchange with my child's doctor as deemed necessary.

I hereby request that the Los Alamos Public Schools cooperate with the prescribing physician and assist with the administration of medication pursuant to the policy of the Los Alamos Public Schools.

Recognizing that the Los Alamos Public Schools are under no obligation to administer such medication, I hereby waive any claim for injury against the Los Alamos Public Schools or its employees arising from the administration or lack of administration of such medication.

Furthermore, I agree to identify the Los Alamos Public Schools and its agents and employees from any claims, suits, judgments, or costs of defense (including attorney's fees) arising from any such claims.

____ ________________
Signature, Custodial Parent/Guardian Date

____ ________________
Signature, School Nurse Date Received