Covington Exempted Village Schools

Administration of Prescription Medication at School

Physician's request for the administration of prescribed medication during school hours.

_____ is under my care and should receive the following:
Student's Name

Medication: _____ Dosage: _____

Time to be Administered: _____

Expiration date of this request: □ End of school year, or _____
(Date)

[Expiration date will be end of school year unless otherwise noted.]

Staff to note the following possible side effects: _____

_____

_____ _____ _____
Physician Signature **Date** **Phone**

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A. I will assume responsibility for safe delivery of the medication to school. The medication must be received by the school in the original container in which it was dispensed by the prescriber or a licensed pharmacist.

B. I will notify the school immediately if there is any change in the use of the medication or the
prescribed treatment. You must submit to the District a revised medication form if any of the information contained in the medication order changes.

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's Signature **Date** **Phone**

_____ _____
Parent's Email Address **Student's Grade/Teacher**