ASHLAND CITY SCHOOLS

Administrative Offices 1407 Claremont Ave PO Box 160 Ashland Ohio 44805 419-289-1117 Fax 419-289-2303

PARENT'S REQUEST
FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his delegate (school nurse or other responsible person) to administer the following medication to my child.

Furthermore, I/We understand that it is my/our responsibility: (1) to deliver the medication to the school, (2) that prescribed medicines shall be stored in the **ORIGINAL, LABELED** container: (3) to notify the school in writing of any changes in medication

Student Name: _____

Name of Drug: _____ Dosage: _____ Route: _____

at the following time(s) _____

Name of Drug: _____ Dosage: _____ Route: _____

at the following time(s) _____

Name of Drug: _____ Dosage: _____ Route: _____

at the following time(s) _____

No employee who is authorized by the Board of Education to administer a prescribed drug and who has a copy of the most recent physician's statement, will be liable to civil damage arising from the administering or failure to administer the drug, unless the employee acted in a manner that would constitute negligence or misconduct.

_____ _____

Signature Date