Release for Administration of Medication

Boone Central Public Schools
School Year 2025/20256

Prescription or Over the Counter (OTC) medication must be brought to school in a container appropriately labeled and provided by Parent/Guardian.

Student Name:_____ Date:_____

Allergies:_____ Grade:_____

Healthcare Provider:_____ Teacher:_____

1. Medication:_____
   Dose:_____
   Time(s):_____
   Reason for medication:_____
   Is this medication taken at home? ▢ Yes ▢ No
   Length of time to be taken:
   ▢ Entire School Year ▢ _____ Months ▢ _____ weeks
2. Medication:_____
   Dose:_____
   Time(s):_____
   Reason for medication:_____
   Is this medication taken at home? ▢ Yes ▢ No
   Length of time to be taken:
   ▢ Entire School Year ▢ _____ Months ▢ _____ weeks

I request that the school nurse or trained personnel administer the following medication(s) to my child for the time specified. I accept responsibility for monitoring the effects of this medication and absolve school personnel and the school district from any liability stemming from adverse reactions and all other adverse effects which may occur because of the administer of such medication. I understand if there are any changes in this medication such as dose change, discontinuation, or change in administration times I will notify the school nurse immediately.

_____ _____
Parent/Guardian Signature Date