OWEN J. ROBERTS SCHOOL DISTRICT

AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

Child's Full Name: _____ Grade: _____
Date of Birth: _____ Allergies: _____

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PHYSICIAN'S REQUEST

Name of prescribed medication(s): _____
Reason: _____ Dose: _____
Route: _____ Time to be given at school: _____
Side effects: _____
Medication is to be administered ☐ entire school year ☐ daily ☐ prn

_____ _____
Physician Signature **Printed Name**

_____ _____
Date **Phone Number**

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PARENT REQUEST

I, the parent/guardian of _____ request that the nurse of the Owen J. Roberts School District administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Owen J. Roberts School District and its Board of Directors and all of its employees unless the District is negligent with regard to any claim for injury in connection with dispensation of the prescribed medication.

Additionally, I agree to provide the medication to the school in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instruction if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication/medical condition

_____ _____
Signature of Parent/Guardian Date

List all medication currently being taken by child: _____