

RELEASE OF MEDICATION RESPONSIBILITY

REQUEST FOR STUDENT TO CARRY MEDICATION

I request _____ to carry _____
(name of student) (name of medication)

the medication to be taken properly and according to the doctor's orders. I also take full responsibility for the safety of the medication, so that it does not fall into the hands of any other student and is not taken by any other student. The medication will be in its original container at all times.

Student's name _____

Name of medication _____

Dosage _____

Times to be taken _____

Length of time medication is to be carried by the student _____

If there is any change in the medication, consultation with the school nurse is required.

Date _____

Parent or Guardian's signature _____