

Release for Administration of Medication

Boone Central Public Schools

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, or other effects from an incorrect medication, dosage, or administration time. 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.

Parent/Guardian Signature

Date