Permission Form for Prescribed Medication and All Over-the-Counter Medication (including Ointments and Creams)

School: _____

_____

_____

Morrice Area Schools

Date form received by the school: _____

Student: _____ Date of Birth or Age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician for prescription medication or parent/guardian for over the counter medication. Name of medication: _____

Reason for medication: _____

Form of medication/treatment: _____

Δ Tablet/cap Δ Liquid Δ Inhaler Δ Injection Δ Nebulizer

Δ Other _____

Specific instructions (dose/frequency to be given at school): _____

Start: Δ date form received Other dates: _____

Stop: Δ end of school year Other date/duration: _____

Δ For episodic/emergency events only

Restrictions and/or important side effects: Δ None anticipated Δ Yes. Please describe: _____

Special storage requirements: Δ None Δ Refrigerate

Other: _____

This student is both capable and responsible for self-administering this medication:

Δ No Δ Yes-Supervised Δ Yes-Unsupervised

This student may carry this medication: Δ No Δ Yes

Please indicate if you have provided additional information:

Δ On the back side of this form Δ As an attachment

Date: _____ Signature: _____

Physician's Name: Address: Phone:

To be completed by parent/guardian

I request that _____ receive the above medication at school according to standard school policy.

Name of child

I request that _____ be allowed to self-administer the above medication at school according to the school policy.
Name of child

Date: _____ Signature: _____ Relationship: _____

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RELEASE OF LIABILITY / WAIVER

I acknowledge that the information and instructions provided (**on page 1 of the Medication Permission Form**) for dispensing prescribed and non-prescribed medication to my minor child or ward, _____ (**print first and last name of minor child**) is accurate. I recognize and acknowledge that there are certain risks of physical injury in connection with administering prescribed and non-prescribed medication(s) to my minor child or ward. In consideration of the District administering medication to my minor child or ward, I fully release or discharge the District, its' officers, agents, volunteers and employees from any and all claims from injuries, damages and losses that I, my minor child or ward may have arising out of, connected with, incidental to, or in any way associated with the administering of prescribed or non-prescribed medication. I further agree to indemnify and hold harmless, the District, its' officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by my minor child or ward arising out of, connected with, incidental to or in any way associated with the administering of prescribed or non-prescribed medication. I understand that it is my responsibility to inform the District if any changes in the dispensing of prescribed or non-prescribed medication changes. If such change occurs, I will complete an updated medication form that reflects those changes.

By signing this Release of Liability / Waiver Form, I represent that I am the Parent / Legal Guardian of _____, who is under eighteen (18) years of age. I represent that I've read the above referenced Release of Liability / Waiver provision and am fully familiar with the contents thereof.

To be completed by Parent/Legal Guardian

_____ _____ _____

Signature of Parent or Legal Guardian | Relationship

_____ _____

Print Name of Parent or Legal Guardian | Date