

# 2008-2009 STUDENT MEDICATION AUTHORIZATION FORM

\*\*Any prescribed medication to be administered during school hours must be in the ORIGINAL LABELED CONTAINER AS DISPENSED BY THE PHARMACIST.

Date \_\_\_\_\_

My child, \_\_\_\_\_, has been prescribed

(Child's Name)

\_\_\_\_\_ by Doctor \_\_\_\_\_.

(Rx Number)      Name      (Pharmacy)

He/she will take \_\_\_\_\_ at \_\_\_\_\_.

\_\_\_\_\_ Daily      \_\_\_\_\_ As Needed      \_\_\_\_\_ Other \_\_\_\_\_

I hereby authorize the following personnel to administer this medication to my child.

(Please check.)

\_\_\_\_\_ Teacher/Substitute Teacher      \_\_\_\_\_ School Staff Personnel

\_\_\_\_\_ Other (Please specify) \_\_\_\_\_

- I release the school and school board members, officers and personnel, and will hold Parkview Baptist School and such persons harmless, from any damages, liability or loss resulting from compliance in good faith with this request and authorization.
- I recognize that I am primarily responsible for administering medications to my child and realize that Parkview Baptist School is not assuming my responsibility for my child's care, but is acting on my behalf where I am unable to personally administer a medication.

\_\_\_\_\_  
(Signature of Parent/Guardian)

Comments: \_\_\_\_\_