School Medication Waiver

The following is to be completed by the Parent or Guardian requesting medication in school

I request that the school nurse or other designated person administer medication as directed by the physician. I authorize the school nurse to communicate with the prescribing physician, when the school or physician wants more information about school symptoms or management. I agree to save and hold the district, its officers, employees or agents harmless from liability, suits or claims, of whatever nature or kind which might arise as a result of administering the medication in accord with this request.

- An adult must deliver the medication, and this completed form to school
- An adult must pick up any unused medication on or before the last day of the school year
- This form will be completed every year

Name of Student: _____ Rm/Teacher: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Telephone number(s)/Name(s) of Contact(s):

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