OAKWOOD SCHOOL DISTRICT

PARENT RELEASE FOR ADMINISTRATION OF MEDICATION

TO: ______________________________ ________________________________
Principal School Name

We (I) the undersigned who are the parent/guardian(s) of ______________________
Student Name

____
Address

request that medication be administered to our (my) child in accordance with the instructions of our physician, Dr. ____
State reason for administration of medication __________________________________

We (I) understand that the administration of said medication is to be done under the supervision of a member of the school staff. Further, we (I) understand that school personnel are not legally obligated to administer medication to any child and therefore, we (I) agree to release the Oakwood City Schools, the Oakwood City School Board of Education, the building principal, the Assisting Employee, and all other employees of the Oakwood City Schools from liability arising from the assistance in the administration of that medication.

Further, we (I) the undersigned, agree to bring the medication to school in a container from the Pharmacist properly labeled by same, this label to include name of student, physician, date, dosage instructions (quantity and time) and name of medication.

Further, we (I) will notify the school immediately if we (I) change physicians or medication or terminate the use of this medication for any reason and will report immediately to the school to pick up the remainder of said medication.

Further, we (I) understand that this authorization is valid for the current school year only, and agree to pick up any remaining medication at the end of the year. At the end of the year any medication that has not been picked up will be discarded.

Signature of parent/guardian____
Home address of individual authorizing administration ___________________________

____

Home Phone _________________________ Work Phone _______________________

SH Form #3 (05/14)