

Collegiate High School 2016– 2017

PERMISSION FOR ADMINISTRATION OF MEDICATION
BY DESIGNATED SCHOOL PERSONNEL IN THE SCHOOL SETTING

I hereby certify that it is necessary for _____
Full Name of Student (Please print)

Student Identification Number (Office Use)

to be given the medication listed below during the school day, including when he/she is away from school property. I understand that such medication may be administered by a non-medically trained staff member to be designated by the administrator. The first dosage of any new medication shall not be administered during school hours due to the possibility of an allergic reaction.

Name of Medication: _____

Amount of Medication and Container Brought to School: _____

Dosage To Be Given: _____

Time(s) of Administration: _____

Beginning Date: _____ Ending Date: _____

Side Effects: _____

Special Instructions/Comments: _____

Emergency Telephone Numbers:

Mother/Guardian Home _____ Work _____ Cell _____

Father/Guardian Home _____ Work _____ Cell _____

Other Emergency Contact _____ Daytime Phone _____

Doctor's Name: _____ Telephone _____

Parents are requested to pick up any leftover medicine within **ONE** week after the ending date. Medicine left after this time will be discarded.

It is understood that the Collegiate High School is not required by law to provide medication to my child and therefore in consideration of the school's agreeing to administer such medication I agree to hold the school's employees, representatives and public health personnel free from any and all responsibility for the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them. The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed to be necessary by the school.

Parent/Guardian Signature

Date