MSD of New Durham Township

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

Physician's Statement

I have prescribed the medication listed below for _____

and do hereby authorize the nurse, principal, or their designee (ex: secretary), of Westville School, to administer the medication as directed.

Medication: _____

Dosage/Frequency: _____

The student named above may carry the prescribed EMERGENCY medication for self-administration (circle one) **YES** **NO**

_____ _____

Date Physician's Signature

_____ _____

Physician Phone Number Physician's Name (Printed)

Parent Authorization

I do hereby authorize the school principal, teacher, or other school employee, designated by the principal, to administer the non-prescription medication, as described below, to my child, _____,

in the dosage and frequency directed below.

Medication Name: _____

Dosage: _____

Frequency: _____

I understand that I will be responsible for supplying this medication to the school in the ORIGINAL LABELED CONTAINER as purchased, over-the-counter, to properly identify. I release and agree to hold the Board of School Trustees, its officials, and employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Student Name **Parent/Guardian Signature**

_____ _____

Telephone **Address**

_____

Date

PLEASE NOTE: This authorization is only valid for the current school year. It must be renewed every school year, or the medication will not be given. **Also, medication sent in baggies, unlabeled medicine bottles, envelopes, etc., will not be accepted.**