Permission for Administration of Medication at School

& Release of Liability

STUDENT INFORMATION

Name: _____

Date of Birth: _____

Medication Allergies: _____

MEDICATION ALLOWED TO BE ADMINISTERED

[ ] Ibuprofen

[ ] Acetaminophen

[ ] Antacid

[ ] Cough drops

[ ] Antihistamine

[ ] Antibiotic ointment

PERMISSION FROM PARENT/GUARDIAN

I, _____, request and give permission for trained school personnel acting as "friends" to give my child (named above) the listed medication according to school policy and healthcare provider directions.

I agree to indemnify and hold harmless the school and its employees against any claims, except a claim based on willful and wanton conduct, arising out of administration or childs self-administration of medication.

_____ _____

Parent/Guardian Signature Date