RELEASE FOR ADMINISTERING MEDICATION IN THE HEARTLAND COMMUNITY SCHOOLS

Student Name_____Grade_____Birthdate_____

Date_____Name of Physician_____

I request that school personnel administer medication to my child, _____, as prescribed by said child's physician. (name of child)

I absolve school personnel and the school district from any liability stemming from adverse reactions and all other effects which may occur because of the administering of such prescribed medication.

_____ Date_____

Parent/Guardian signature

PLEASE PRESENT THE MEDICATION IN AN ORIGINALLY LABELED BOTTLE OR CONTAINER WITH YOUR CHILD'S NAME, PHYSICIAN'S NAME, NAME OF MEDICATION AND DOSAGE.

Name of Medication_____

What time is each dose to be given_____
If given PRN (as needed only) specify the length of time between doses.

How much or how many to be given_____

What days medication should be given_____

Reason for taking medication_____

Comments:_____
_____
_____
_____