School Medication Authorization Release Form
(To be returned to school)

Student's Name _____ Birth Date _____

Address _____ Home Phone _____

School _____ Grade _____

Emergency Phone Number (s) _____

TO BE COMPLETED BY STUDENT'S PHYSICIAN IF PRESCRIPTION MEDICATION OR BY PARENT IF NON-PRESRIPTION MEDICATION

Name of Medication _____

Dosage _____ Frequency _____ Time to be given at school _____

Date of Prescirption _____ Date of order _____

Discontinue Date _____

Diagnosis Requiring Medication _____

*Must this medication be administered during the camp day in order to allow the child to attend school or to address the student's medical condition? _____

Expected side effects, if any _____

Other medications students is receiving _____

Physician's Name _____ Physician's Signature _____

Address _____

Phone (office) _____ Phone (emergency) _____

Further Instructions or Remarks _____

_____ Date _____

TO BE COMPLETED BY PARENT:

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of medical emergency, I hereby authorize the Madison County Regional Office of Education and its employees to administer or attempt to administer to my child lawfully prescibed medication in the manner descibed above. I acknowledge that it may be necessary for the administration of medicatio to my child to be performed by an individual other than a shcool nurse, and specifically consent to such practices. I further acknowledge and agree that wehn the lawfully prescribed medication is administered, I waive and claims I might have against the ROE, it's employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempt of administration of said medication.

Parent's Signature _____ Date _____