PATRICK COUNTY PUBLIC SCHOOLS
P.O. Box 346 – 104 Rucker St.
Stuart, VA 24171
276-694-3163

AUTHORIZATION / PARENTAL CONSENT FOR GIVING MEDICATION AT SCHOOL

(Complete only if your child is to be given medication at school, ex. Aspirin, Advil)

SCHOOL YEAR:

STUDENT NAME:_________________________, ____________________ ______
(Last Name) (First Name) (M.I.)

DATE OF BIRTH:______________ ALLERGIES:____________________________

I am parent or guardian of ____________________________ and I request the designated school personnel responsible for medications to give my child the following medication while in school.

NAME OF MEDICATION:____

REASON(S) FOR MEDICATION:____

DOSE:_______________________________ TIME:________________________

EXPECTED DURATION OF TREATMENT:________________________________

POSSIBLE SIDE EFFECTS:____

I understand that the medication is to be furnished by me in the bottle supplied by the drug store with the label intact. Any over-the counter medication, (including cough drops), must have the name and directions for administering written legibly on the bottle. I understand that it is my responsibility to keep at school at all times the necessary medication with an unexpired expiration date.

I hereby acknowledge that I have read and understood the Patrick County School Board Regulations relating to taking of medications. I hereby release <u>Patrick County Public Schools</u> and its employees from any claims or liability with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

______________________________ _____________________ ____________
Parent/Guardian Signature Daytime Phone Date