PATRICK COUNTY PUBLIC SCHOOLS
P. O. Box 346 – 104 Rucker Street
Stuart, Virginia 24171
(276) 694-3163

AUTHORIZATION / PARENTAL CONSENT FOR GIVING MEDICATION AT SCHOOL

Student's Last Name_____________, First Name______________ M.I._____

Date of Birth______________ Allergies_______________________________

I am the parent / guardian of _________________________ and I request the designated school personnel responsible for medications to give my child the following medication as prescribed by Dr. ____________________________ while in school.

Name of Medication____

Reasons 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 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 Stuart Elementary School 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. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

______________________	______________________	______________________
Parent/Guardian Signature	Daytime Phone	Date