2016-2017 - The Graham School

PARENT'S REQUEST FOR ASSISTANCE IN THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the school designee to assist in administering Over the Counter medication to my child:
First/Middle/Last Name: _____ Date of Birth _____
Address of Student _____
Over the Counter medications available are Tylenol, Advil, Pepto-Bismol, Tums and cough drops.

Consent to Administer Over the Counter Medication

_____	_____	_____	_____
Date	**Signature of Parent/Legal Guardian**	**Home Phone**	**Cell Phone**

PHYSICIAN'S STATEMENT TO AUTHORIZE DISPENSING MEDICATION

To the Physician:

The Graham School urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the receiving and consumption of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school. I verify that this medication must be taken by:

_____	_____	_____
Name of Student	Medication	Dosage

Medication is to be taken at the following times: _____
Instructions or precautions: _____
Possible side effects or reactions: _____
Action to be taken if side effects observed: _____
Beginning date prescription _____ Expiration date prescription _____
Physician's Signature _____ Physician's Printed Name _____
Phone # _____ Physician's Address _____

I/We understand and acknowledge that school personnel are under no obligation to render the assistance requested and that such assistance may be rendered by an employee who is not medically trained. I/We hereby release The Graham School, its Board of Education, its officials and employees from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested. Furthermore, I/We understand the parental responsibility to be: (1) to deliver the medication to the school; (2) to notify the school if the child changes physicians; (3) to obtain a revised statement, signed by the physician who originally prescribed the drug, and to deliver it to the school, when the child's therapy is changed in any manner; and (4) to recover any medication not administered by the school.

_____	_____	_____	_____
Date	Signature of Parent/Legal Guardian	Home Phone	Cell Phone

A new form must be completed for each change and each school year.