

Physician's School Medication Form

Name of Student: _____ Grade: _____ Age: _____

The above named person is a patient of mine and is currently under my medical care. Due to a medical condition the medication listed below needs to be (given, taken, injected) during regular school days according to the following protocol:

Medication: _____

Time to be given: _____

Direction for administering medication: _____

If an emergency situation occurs during the school day, or if the pupil becomes ill, school officials are to:

- a. Contact me at my office: _____
- b. Take child immediately to the emergency room at: _____
- c. Other Option: _____

The medication for this pupil from me will be properly labeled and will carry my name as the prescribing physician.

_____ Date _____ Physician's Signature

RELEASE OF LIABILITY FORM

I, _____, the parent and/or legal guardian of _____, enrolled at RCA importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician, I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of the school year _____.

_____ Parent or Guardian's Signature _____ Date

_____ Principal's Signature _____ Date

FOR SCHOOL USE ONLY

Date Physician's School Medication Form Expires: _____

| Please be reminded, form will expire one (1) year from date of physicians' signature.