PHYSICIAN AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours. Physician's Printed Name Physician's Signature Physician's Signature Date Please regard my signature below as my assurance that I release School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of out child's taking or failing to take this medication at the times prescribed. I also agree to keep the school inform in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They	Student			
Times of Day to be Administered Number of Times/Intervals Medication is to be Administered Date to Begin Medication Date to End Medication Adverse/Severe Reaction that Should be Reported to Physician Special Instructions for Administration of Medication This medication can be safely administered by non-medical personnel It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours. Physician's Printed Name Tel Physician's Signature Date Please regard my signature below as my assurance that I release School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of outhild's taking or falling to take this medication at the times prescribed. I also agree to keep the school inform in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction. Parent's Printed Name Tel	Address			
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