

HAMILTON LOCAL SCHOOLS

775 Rathmell Rd., Columbus, OH 43207

MEDICAL AUTHORIZATION FORM

Parent Request for Administration of Medication

By School Personnel

PHYSICIAN

Please Print

_____ is under my care and should receive
(Name of student)

(Name of drug, dosage, route)

at the following times: _____

Specific instructions for administration: _____

Possible side effects to watch for: _____

Expiration date of this request: _____

Date: _____
(Physician's Name) (Physician's Signature)

(Physician's telephone number)

PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his designee (e.g., school nurse or other responsible person) to administer the following medication to my child. Further, I understand that the school personnel are not legally obligated to administer oral medication to any child, and therefore, I agree to hold the school district and it's employees free from any and all responsibility for the results of such medication or the manner in which it is administered, and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

Name of Student: _____ Grade: _____

Name of Drug: _____ Dosage: _____ Route: _____

Administer at the following times: _____

Expiration date of this request: _____

Signature of Parent/Guardian: _____ Date: _____