AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

TO: _____
Full Name of Building Administrator

_____ must receive the following prescribed and/or non-prescribed medication, including vitamins and herbs, during school hours in order to maintain sufficient health to participate in the school program.

Name of medication: _____

Name of vitamins/herbs: _____

Prescribed dosage: _____

Time schedule: _____

Reason of need to administer medication and/or vitamin/herb during school day:

_____

Length of time: _____ days _____ months _____ indefinitely

Possible side effects: _____

_____
Signature of Physician Date

I do hereby release, discharge and hold harmless the McGuffey School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication, and/or vitamins and herbs to my child should the child develop a reaction from the medication.

_____
Signature of Parent/Guardian Date