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| **PERRY COUNTY SCHOOL DISTRICT PERRY COUNTY SCHOOL DISTRICT**  **PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:**  The undersigned parent/s or guardian/s of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor child, has requested personnel(s) of the Perry County School District to administer the prescribed medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that the school administration will designate a school personnel(s) (who will not need a medical or nursing licenses) to assist &/or observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The unsigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney’s fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the \_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of Parent/Guardian Witness** |

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| **TO BE COMPLETED BY PARENT/GUARDIAN**  Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB/Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HT\_\_\_\_\_\_\_\_WT\_\_\_\_\_\_\_\_ Allergies/Reactions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I request my child name and identified above to receive:  \_\_\_\_\_ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.  \_\_\_\_\_Non-prescription/over-the-counter medication provided by me along with Dr.’s order  I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I consent to communication between the prescribing physician, the Pharmacist, and the school nurse, necessary for the management and administration of medications pertaining to my child’s medical condition. I authorize the school nurse &/or the school administration to designate a school personnel(s)(who will not need a medical or nursing licenses) to assist &or observe my child taking the prescribed medication ordered by a physician that is listed below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter.  **Signature of Parent/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Emergency Contacts: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **PRESCRIBER AUTHORIZATION (TO BE FILLED OUT BY THE DR.)**  StudentName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength [**Total # milligrams(MG**)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dosage **[# of pills to take/ liquid to take**]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency (**Time to be given at school)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date to begin medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date to stop med.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for taking the medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Potential side ffects/adversereactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any special instructions or Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name of Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**If Benadryl is needed, see *back* page (Page 4)**

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| **PERRY COUNTY SCHOOL DISTRICT PERRY COUNTY SCHOOL DISTRICT**  **PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:**  The undersigned parent/s or guardian/s of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor child, has requested personnel(s) of the Perry County School District to administer the prescribed medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that the school administration will designate a school personnel(s) (who will not need a medical or nursing licenses) to assist &/or observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The unsigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney’s fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the \_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of Parent/Guardian Witness** |

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| **TO BE COMPLETED BY PARENT/GUARDIAN**  Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB/Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HT\_\_\_\_\_\_\_\_WT\_\_\_\_\_\_\_\_ Allergies/Reactions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I request my child name and identified above to receive:  \_\_\_\_\_ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.  \_\_\_\_\_Non-prescription/over-the-counter medication provided by me along with Dr.’s order  I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I consent to communication between the prescribing physician, the Pharmacist, and the school nurse, necessary for the management and administration of medications pertaining to my child’s medical condition. I authorize the school nurse &/or the school administration to designate a school personnel(s)(who will not need a medical or nursing licenses) to assist &or observe my child taking the prescribed medication ordered by a physician that is listed below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter.  **Signature of Parent/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Emergency Contacts: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **PRESCRIBER AUTHORIZATION (TO BE FILLED OUT BY THE DR.)**  StudentName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength [**Total # milligrams(MG**)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dosage **[# of pills to take/ liquid to take**]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency (**Time to be given at school)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date to begin medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date to stop med.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for taking the medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Potential side ffects/adversereactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any special instructions or Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name of Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |