Charter School of Excellence

Authorization for Medication to be taken during School Hours

I request that my child. ___________________________, Date of Birth ___________, Grade_____, be assisted in taking medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the medication policy and I understand that this form must be renewed annually and anytime there is a change in drug, time or dose.

I agree to waive the School District. their officers, representatives and employees of liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risk of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claims for acts of negligence by employees of the School District.

Furthermore, as a parent or guardian of the minor child to receive prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless the Charter School of Excellence, officers, and their employees against loss or any claims, demands, causes of action that might be brought by the minor or in his/her behalf to defray the damages incurred by the taking of the prescribed medication and/or treatment given by the School District during regularly scheduled school hours or activities in the School District. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursement or indemnification.

Name of medication to be given at school: ___________________________________

Other medications student is taking: ___________________________________

Allergies: ___________________________________

_________________________ _____________ _________________

Parent/Guardian Signature Date Emergency Contact

The Physician Completes the Following Section:

Name of medication to be given at school: ___________________________________

Diagnosis for which the medication is given: ___________________________________

Dosage: _______________ Time(s): _______________ Route: _______________

Significant side effects: ___________________________________

Dates Medication to be given from: _______________ to _______________

Can this medication be adjusted to accommodate class schedule: yes or no
If yes, by how much time? _______________

Other information: ___________________________________

_________________________ _________________________

Printed Physician Name Physician Phone Number and Fax Number

_________________________ 5/2010

Physician Signature