AUTHORIZATION FOR ADMINISTERING MEDICATION BY SCHOOL PERSONNEL

Name of Student: _____ Grade: _____
Teacher/Advisor: _____

The following medications are kept in stock at Evansville Day School for your convenience. Please circle the medication(s) that you will allow the student to be given as needed. Recommended directions on the bottle will be followed. I authorize school personnel to administer to the student the circled medication(s) listed below. I release and agree to defend, indemnify, and hold harmless Evansville Day School, its employees, and its agents from any and all loss, liability, costs, attorney fees, or claims (including claims of the student) arising from or related to the administering of the circled medication(s) listed below:

Tylenol	**Children's Motrin**
Children's Tylenol	**Benadryl Allergy**
Ibuprofen	**Children's Benadryl Allergy**

_____ _____
Signature of Parent/Guardian **Date**

I authorize school personnel to administer to the student the prescription medication listed below (please complete a separate form for each medication):

Prescription Medication: _____

Prescribing Doctor: _____

Dosage Required: _____

Dates and Time to Administer: _____

Additional Directions (If none, state none): _____

Drug Allergies (If none, state none): _____

I release and agree to defend, indemnify, and hold harmless Evansville Day School, its employees, and its agents from any and all loss, liability, costs, attorney fees, or claims (including claims of the student) arising from or related to the administering of the prescription medication listed above.

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Signature of Parent/Guardian **Date**