MANVEL PUBLIC SCHOOL
2019-2020 SCHOOL YEAR
REQUEST/CONSENT FOR MEDICATION ADMINISTRATION

Student Name_____ Grade_____ Birthdate_____

Known allergies of student_____

May over the counter pain relievers (example: Tylenol, Tums) be given to your child? Yes___ No____

If yes, please specify dose: Adult_____ Junior_____ Children_____

Medication (long term)

Name:_____

Prescription Number:_____

Dose:_____

Time of Day to be Administred:_____

Special Instructions:_____

Possible Side Effects:_____

Possible Effects on Learning and Physical Functioning:_____

_____

Physician:_____

Address:_____Phone:_____

Parent/Guardian Authorization

I request/consent this medication be given to my child in the manner specified here. I give permission to school personnel to administer the medication. I understand that administration of medication will not be done by a nurse. I will notify the school immediately if my child's health status changes, or if there is a change or cancellation of the medication.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend and save harmless the Manvel School Board, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to: costs, reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

Parent/Guardian Signature: _____Date: _____

Address _____

Phone (cell) _____ Phone (home) _____ Phone (work) _____

Please return completed form to the school office.