



Authorization/Parent/Guardian Consent for Administering Medication

****Use a separate authorization form for each medication****

Student Name _____ **School Year** _____ **Date of Birth** _____

Allergies _____

Current medications _____

I am the parent/guardian of _____, I give my permission for him/her to take the following prescribed medication while in Town and Country School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medication during school time. I hereby release Town and Country School and its employees from any claims or liability connected with its reliance on this permission and agree to hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber listed below.

Parent/Guardian Signature _____

Medication Authorization

(For Use by Licensed Prescriber ONLY)

Relevant Diagnosis _____

Medication and Dosage _____

Time(s) _____

Serious reaction/adverse side effects from this medication may occur ____ Yes ____ No

If yes, describe: _____

Asthma/Diabetic ONLY

This student is both capable and responsible for self-administering this medication:

_____ No _____ Yes – Supervised _____ Yes – Unsupervised

This student may carry this medication on his/her person ____ No ____ Yes

Date _____ **Telephone Number** _____

Licensed Prescriber's Name Printed _____

Licensed Prescriber's Signature _____