Parent Release for Administration of Physician-Prescribed Medication

Joliet Township High School recognizes the importance of following a physician's recommendations for physician-prescribed medication at school whenever possible.

The fact that this is a service or accommodation which the school is not legally required to provide is recognized by all parties signing this form, and in so signing they agree to hold the school and its staff free from any liability which might arise out of these arrangements. Medication that can be administered before or after school instead of during the school day will not be administered by school staff. I (We) understand that the School District is not required by law to provide physician-prescribed medication to our son/daughter and, therefore, in consideration of the School District's agreeing to administer such medication, I (we) agree to hold the School District and its employees free from any and all responsibility for the results of such medication(s) or the manner in which it is administered and to indemnify each of them against loss by reason of a civil judgment arising out of these arrangements which may be rendered against them.

I (We) agree to provide the school with the appropriate medication, properly labeled, with proper directions for use in school.

I (We), the undersigned, the parent(s)/guardian(s) of _____ (student's full name) request that medication be administered to our son/daughter in accordance with the instructions of our physician Dr. _____,

Address: _____, Phone # _____,

as set forth on the Physician's Order for Physician-Prescribed Medication. We understand that such medication is to be administered by a member of the school staff to be designated by the principal.

I (We) will notify the school immediately if I (we) change physicians or if this medication is no longer required. I (We) request school authorities to continue administering the specified medication(s) until otherwise notified by me (us) or the above physician. When such notice is given orally, it shall be confirmed in writing within 24 hours.

I am (We are) aware that this medication is self-administered.

I (We) hereby grant permission for the student's physician(s) and the school staff to directly communicate regarding this medication.

I (We) certify that the above-named physician is aware of all medication currently being administered to this student.

The school is authorized to secure emergency medical services for my son/daughter whenever the need for such services is deemed to be necessary by the principal or school staff member.

Mother's/Guardian's Name: _____

Mother's/Guardian's Address: _____

Phone: *Home:* _____ *Work:* _____

Signature of Mother/Guardian: _____ Date: _____

Father's/Guardian's Name: _____

Father's/Guardian's Address: _____

Phone: *Home:* _____ *Work:* _____

Signature of Father/Guardian: _____ Date: _____

(Both parents must sign this form if they are living with or have custody of the student)

School Contact Person: _____ Phone Number: _____

This approval in no way relates to the medical directions or the physician's reasons therefore.

Principal or Designee: _____ Date: _____