PARENT/PHYSICIAN REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER PRESCRIBED ROUTINE MEDICATION
2021-2022

To be completed by Parent/Guardian

NAME OF STUDENT: ____

Date of Birth: YYYY/MM/DD ________________ Health Card #________________
Name of Parent/Guardian: ____
Address: ____
____
Telephone: (Home)____________________Business: ____________________
Contact in case of emergency: ____
Telephone: (Home)____________________Business: ____________________
Name of Physician: ____________________ Phone: ____________________

Medication Prescribed: ____

Dosage ____________________Time of Administration: ____________________

Duration: ____

Why is this medication required? ____

Special Instructions (Storage, etc.): ____

Any specific side effects to your child? ____

With an increasing number of children on daily medications, it is essential that the above information be known.

I understand the reason(s) for and the nature of the administration of prescribed routine medication and I consent to administration of such medication. This consent is valid until **June 30, 2022**. Consent can be withdrawn by written notice to Rotherglen School.
In the event that there are any changes or modifications to the administration of my child's prescribed routine medication, I agree to provide Rotherglen School with a revised form. I/We hereby release, hold harmless and forever discharge Rotherglen School and any of its respective directors, officers, employees and agents, for any and all actions, causes of action, claims and demands for damages, indemnity, costs, interest, loss or injury of every nature and kind whatsoever and howsoever which I/ we have had, may now have or may hereafter have, in any way arising from the administration of prescribed routine medication.

Signature of Parent/Guardian ____________________Date ____________

Please print name____________________________