

## STUDENT MEDICATION AUTHORIZATION

As the parents/guardians of \_\_\_\_\_, we request and authorize staff members of The San Francisco School to administer medication and health aids to our child. We understand it is our responsibility to provide clear written instructions for the staff members of The School to follow in administering the medication and/or health aids. We further understand that The School will endeavor to have its staff follow the instructions; however, we recognize that the staff of The School are not specially trained for this purpose. We also understand that there may be occasions where the medication and/or health aids might not be administered within the designated time frame, is not administered properly, or is not administered at all for whatever reason, including preoccupation with other demands as well as human error. We agree, on behalf of ourselves and our child, to assume the risks of and to hold harmless and indemnify The School, its staff members and other employees from any claims which may arise from the staff's administration or failure to administer medications and/or health aids. This Student Medication Authorization shall remain effective through the period of time noted below.

Date: \_\_\_\_\_  
Custodial Parent's Signature \_\_\_\_\_ Print Name \_\_\_\_\_

### The following information is to be supplied by custodial parent/guardian:

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Frequency/Times: \_\_\_\_\_

Duration: start date \_\_\_\_\_; end date \_\_\_\_\_

Prescribing physician's name: \_\_\_\_\_

Physician's telephone number: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_

Pharmacy's telephone number: \_\_\_\_\_

This form and the medication, in its original container, were hand delivered to

\_\_\_\_\_ (name of teacher or other staff person)

on \_\_\_\_\_ (date).

Date: \_\_\_\_\_  
Parent's signature \_\_\_\_\_ print name \_\_\_\_\_

Parent's daytime phone number where reachable today: \_\_\_\_\_

