Permission Form for Administration of Medication

STUDENT'S NAME: _____ **BIRTH DATE:** _____

PARENT'S PHONE: _____ **TEACHER:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

REQUEST AND APPROVAL OF PARENT/GUARDIAN:
I hereby request and give permission for the medication prescribed herein to be administered to my child who is named above for the duration indicated. I release London Waldorf School, its employees and agents from any liability for loss, damage or injury, howsoever caused, to my child's person or property arising out of administering, or failure to administer the procedure as provided herein.

Parent's/Guardian's Signature : _____ **Date Signed:** _____

Please Note:
All medication is the responsibility of the parents/guardians and must be delivered to the school in the original container provided by the pharmacist. It must be clearly labeled, specifying the student's name, the medication, the prescribed dosage, the frequency, and the method of administration.

It is the parent's/guardian's responsibility to notify the office of any changes in the medication or in the administration of that medication. This authorization will expire on the date indicated by the physician or on June 30th of each school year, whichever comes first.

STATEMENT OF PHYSICIAN (or Parent for non-prescription medicines)**:**

1. **Name/type of medicine:**

_____

_____

2. **Dosage/amount to be given:**

_____

_____

3. **Frequency/times for administration:**

_____

_____

4. **Instructions for administration:**

_____

_____

5. **Duration:**

_____

_____

6. **Reason for Administration (Symptoms to look for):**

_____

_____

7. **Possible reaction to medication/side effects:**

_____

_____

Physician's Name _____ **Telephone Number** _____

Address _____

Physician's Signature _____ **Date Signed** _____