Endeavor Hall

Medication Administration Release Form

I hereby certify that __________________________has previously had at least one dose of the prescribed medications(s) listed below and did not have an adverse reaction from it. I request that this medication be administered as needed at school as prescribed by the physician. I understand that any school employee who administers this prescription to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of adverse drug reaction suffered by the student, because of administering such a drug or because of a mislabeled or altered product. I hereby authorize endeavor Hall personnel to exchange information regarding dispensing and monitoring of this medication with ______________________, the attending physician or dentist, or with the pharmacy as identified on the label of the prescribed medication container.

______________________________________
Signature of Parent/Guardian

______________________________________
Printed Name of Parent/Guardian

______________________________________
Date

NOTE: The medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the student, medication, dosage and times to be administered.

Teacher/Grade (2019-2020) ______________________

Student’s name ______________________________

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<thead>
<tr>
<th></th>
<th>Medication #1</th>
<th>Medication #2</th>
<th>Medication #3</th>
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<tbody>
<tr>
<td>Dosage</td>
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<td>Special Instructions</td>
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<td>Time of dosage</td>
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</tbody>
</table>

Physician’s Signature: ________________________________

Phone number: __________________ Fax number: __________________ Date: __________________
