LOYALSOCK TOWNSHIP SCHOOL DISTRICT
REQUEST FOR ADMINISTRATION OF MEDICATION

Grade/Teacher _____ Building _____ School Year _____

We, _____
(Names of Parent/Guardian)

specifically release from liability, including negligent acts and/or omission, any and all Loyalsock township School District employees, who under prescribed conditions (physician's prescription attached) administer:

_____
(Description and/or Name of Medication)

to my child:

_____
(Print First and Last Name of Student)

We shall provide the medication as prescribed for the period of time as directed by the physician in a container provided by the pharmacist.

My signature authorizes the Loyalsock Nursing Staff and the prescribing physician to share information related to the administration of this prescription throughout the school year noted above.

_____ _____
Parent/Guardian Signature Date