LOYALSOCK TOWNSHIP SCHOOL DISTRICT
REQUEST FOR ADMINISTRATION OF MEDICATION

Teacher/Grade Building School Year

I, _____
(Name of Parent/Guardian)

authorize the Loyalsock Township School District and its nurses to give the following medication and 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:

_____
(Name of student)

My signature authorizes the Loyalsock Township School District and its nurses and/or designated employees to give the above medication to my child. I shall provide the medication as prescribed for the period of time as directed by the physician in a container provided by the pharmacist.

Non-prescription medication will be labeled with the name of the student and be kept in its original container/package.

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

Parent/Guardian Signature Date