MARIETTA CITY SCHOOLS

Assistance with Medication

School________________________________Teacher_________________Grade_________________

Student's Name_________________________Date of Birth__________________________________

Special Instructions:____
____.

Name of Medication______________________________Dosage_____________________________

Time to be taken__________AM___________PM or as Needed________every___________hour(s)

How is medication to be administered?___by mouth ___eye drop ____ear drop ___topical ___other

Possible side effects____

This request is valid from (dates)______________________to________________________________

NOTE: PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL CONTAINER FROM THE PHARMACY. ONLY THE INSTRUCTIONS FOR DOSAGE AND TIMES FOR ADMINISTRATION WRITTEN ON THE CONTAINER OR RECEIVED FROM THE PHYSICIAN WILL BE FOLLOWED. PARENTS ARE RESPONSIBLE FOR PERSONALLY COLLECTING FROM THE SCHOOL ANY UNUSED PORTION OF THE MEDICATION WITHIN ONE WEEK AFTER EXPIRATION OF THE MEDICATION AND/OR PHYSICIAN'S ORDER. MEDICATION THAT IS NOT PERSONALLY COLLECTED BY THE PARENT/GUARDIAN WILL BE DESTROYED.

I authorize the personnel of ___________________________to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse Marietta City Schools, the individual members, agents, employees and representatives thereof, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages or injuries arising out of, during or in connection with the administering of this medication.

Signature of
parent/guardian_____________________________ Date_________________________