

SAN JOSE EPISCOPAL DAY SCHOOL, INC.

Parent permission for the administration of prescribed and over-the-counter medication.

DATE _____

STUDENT _____ TEACHER _____

NAME OF MEDICATION _____

PRESCRIPTION NUMBER _____ PRESCRIPTION DATE _____

DOCTOR ADMINISTERING MEDICATION _____

DOCTOR ADMINISTERING MEDICATION PHONE NUMBER _____

START DATE _____ DISCONTINUE DATE _____

AMOUNT TO BE GIVEN _____ TIME(S) TO BE GIVEN _____

RETURN MEDICATION HOME DAILY YES _____ NO _____

REFRIGERATION REQUIRED YES _____ NO _____

SPECIFIC INSTRUCTIONS (i.e. give with water, before/after meal) _____

I grant permission for the Principal or the Principal's designee to assist in the administration of the prescribed over-the-counter medication for the above named child. I certify that the prescribed medication is in its ORIGINAL container and that it is necessary, according to my doctor's instructions, for this medication to be provided during the school day, extended day care, or times when my child is away from school property on official school business. I understand that this medication will be given only according to the directions on the label as prescribed by the doctor, or the directions on the over-the-counter medication. Further, I agree to waive any claims of liability that may arise against any school personnel relative to the administration of medication to my child/legal ward according to these directions.

ALL MEDICATION MUST BE BROUGHT TO THE SCHOOL OFFICE - NOT THE CLASSROOM.

Signature of Parent/Legal Guardian