SHERIDAN COUNTY SCHOOL DISTRICT #3

AUTHORIZATION FOR ADMINISTRATION OF MEDICINE AND RELEASE OF LIABILITY

_____

Head Coach Assistant Coach

and their designees as personnel of Sheridan County School District No. 3, State of Wyoming, to administer the following medication to:

Name of Child: _____

Date of Birth: _____

School: _____

Grade: _____

Name of Medication: _____

Dosage: _____

Time of Day Medication is to be Given: _____

Possible Side Effects: _____

Anticipated number of days medication needs to be given: _____

Name of Prescribing Physician: _____

Name of Dispensing Pharmacy _____

In consideration of District personnel administering such medicine, the undersigned hereby releases said District and it's personnel from claims, demands and liabilities, direct and indirect, which may result or accrue by reason of the administration of such medicine, the failure to administer it, or the improper administration thereof. The school nurse may exchange medical information with prescribing physician when necessary.

1. I have read and understand this authorization. I hereby give my permission for _____ to take the above prescription or over-the-counter medication as directed.

OR

2. I give permission for _____ to take his/her inhaler as he/she has been instructed.

I understand that it is my responsibility to furnish this medication.

_____

Signature of Parent or Legal Guardian Date

PARENT NOTE:

Student medication must be in the prescription bottle or in the original (unopened) bottle it came in.