PERMISSION FORM FOR ADMINISTERING MEDICATION IN SCHOOLS

Student's Name				Date of Birth	
School		Grade		Teacher	
Address		Home Phone			
Parent/Guardian's Name		Work Phone			

TO BE COMPLETED BY PHYSICIAN:

Best Peak Flow	
Medical condition necessitating medication:	
Name of Medication(s):	Possible Side Effects
Directions for medications:	
Option for Medication administration (check one):	
o	Self-administration (unsupervised) as instructed by _____ physician _____ parent
o	Supervised administration (supervised by nurse or principal's designee)

Physician's Signature _____Date_____

TO BE COMPLETED BY PARENT/GUARDIAN:
The medication(s) listed above must be taken during school hours as directed by the physician. I grant permission for the Los Alamos Public Schools to exchange information with my child's doctor as deemed necessary.

I hereby request that the Los Alamos Public Schools cooperate with the prescribing physician and assist with the administration of medication pursuant to the policy of the Los Alamos Public Schools.

Recognizing that the Los Alamos Public Schools are under no obligation to administer such medication, I hereby waive any claim for injury against the Los Alamos Public Schools or its employees arising from the administration or lack of administration of such medication.

Furthermore, I agree to indemnify the Los Alamos Public Schools and its agents and employees from any claims, suits, judgments, or costs of defense (including attorney's fees) arising from any such claims.

Parent/Guardian's Signature: _____Date: _____

School Nurse's Signature: _____Date: _____
Adopted 5/09
Revised 4/10