

ALCESTER – HUDSON COMMUNITY SCHOOL #61-1

AUTHORIZATION AND RELEASE FOR MEDICATIONS

I hereby request and authorize officials at ALCESTER-HUDSON SCHOOL to supervise the below stated medication for:

Student's name _____

Date _____ *Grade* _____

As Prescribed by Dr. _____

Medication _____ *Dosage* _____ *Time* _____

Method: *Oral* _____ *Topical* _____ *Inhalation* _____

Reason Child Is Taking Medication _____

Precautions and Reactions to Observe and Report _____

I understand that the school district and individuals involved will not be held liable from any adverse effects of the medication.

I understand the medication shall be provided in a bottle showing the name and telephone number of the Pharmacy, the student's name, Physician's name and dosage of the drug to be taken.

Date

Parent/Guardian Signature

Date

Phone call from Parent/Guardian

Call received by: _____