THE FRISCH SCHOOL
ישיבת פריש
The Henry & Esther Swieca Family Campus

AUTHORIZATION TO GIVE OVER THE COUNTER MEDICATION IN SCHOOL

Student Name: _____ Grade: ____Name of Medication:_____

Dosage: _____Frequency To Be Given and Directions_____

Purpose of Medication: _____

I authorize the School Nurse or another school employee trained by the nurse to administer the above medication to my child during regular school hours and at other times when my child is participating in a school related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; that I will indemnify and hold harmless the district, school, school nurse and other school employees against any claims arising from the administration to my child. (**Parent's signature required**)

Parent/Guardian Signature_____

Date_____

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOl

If your child is taking daily medication, please complete the following:

Student Name_____ Grade_____

Name of Medication _____

Dosage: _____ Frequency_____ Time_____

Purpose of the medication_____

Parent'/Guardian Signature_____

Date_____

Signature of M.D. _____

Address _____

Phone _____

Date _____

This permission is effective for the current school year only and must be renewed annually.

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