# MEDICATION ADMINISTRATION

I / We hereby request that the Turkeyfoot Valley Area School District, through its appropriate personnel, administer a physician's prescribed medication to our child, as described below. I / We further hereby release and hold harmless, the Turkeyfoot Valley Area School District and its employees, from any liability for injury or damages as a result of such administration of medicine.

DATE:_____

PARENT/GUARDIAN SIGNATURE:_____

Consistent with the above request by the parents of the below identified child, I hereby request that the Turkeyfoot Valley Area School District allow its appropriate personnel to administer a medication which I have prescribed, as follows:

(a). Child's name: _____

(b). Name of Medication: _____

(c). Dosage: _____

(d). Time to be Administered: _____

(e). Purpose of Medication: _____
_____

(f). Possible Side Effects or Contraindications: _____
_____

(g). Termination date for Administering the Medication: _____

(h). Diagnosis: _____

(i). Other medication prescribed by the physician that the student is taking outside of school hours:_____

(j). Curtailment of specific school activity:_____
( sports, shop, lab, gym, EtC)

_____
DATE

_____
PHYSICIAN'S SIGNATURE

_____
Physician's Telephone Number