**ALTERNATE LEARNING CENTER - ADMINISTRATION OF MEDICATION**
**2016/2017 School Year**

**A completed form shall be on file for any student requiring medication during school hours.**

Student's Name _____ Date of Birth _____
Parent/Guardian's Name _____ Phone No. _____
Address _____

***To be completed by Physician***

Name of Medication _____
Purpose of Medication _____
Dosage _____ Frequency _____ Method _____
Anticipated and/or possible reaction(s) of student to medication _____
_____
Side affects which should be reported to physician _____
Special instructions (storage / sterile requirements) _____
Expiration date of this request (limited to one school year) _____

Date _____ Physician's Signature _____
Address _____ Phone No. _____

***To be completed by Parent***

We (I) the undersigned, who are the parents/guardians of the previously mentioned child request that the health care service as outlined and prescribed by the above physician be provided to our child. We (I) authorize the school to appoint a designated person(s) to the school personnel immediately if there is any change in either the child's treatment regime or the authorizing physician.

In consideration of the administration of medical services as above required and authorized, the undersigned, for himself/herself/themselves, his/her/their heirs, executors, administrators and assigns, does/do hereby waive, release, discharge and forever quit claim Educational Service Center of Lake Erie West, its members, officers, administrators, agents, employees and servants from and against all claims, demands or causes of action for loss, cost, injury or damage whatsoever arising from or out of the administration of medical services as requested and authorized.

In further consideration of the administration of medical services as required and authorized, the undersigned does/do hereby agree to indemnify and save harmless the Educational Service Center of Lake Erie West, its members, officers, administrators, agents, employees and servants from and against any/all claims, demands or causes of action by any person, persons or entities for loss, cost, injury or damage alleged to arise from or out of the administration of medical services as requested and authorized above.

Signature of parent(s) / guardian(s) _____ Date _____

***School Section***

The undersigned school principal and each person authorized to administer the medication or procedure requested and authorized above hereby acknowledge receipt of the above request and certify that they understand the information contained in it.

Principal Signature _____ Date _____

Signature and Title of other _____ Date _____
Authorized Personnel _____ Date _____