Date: _____ Grade: _____

CRESTWOOD SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

My child, _____, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medicine in an appropriately labeled, original pharmacy container.

Physician Authorization

Name of Medication: _____

Prescribed dosage: _____

Time schedule: _____

List side effects of medication: _____

Diagnosis and necessity of medication during school hours: _____

_____

Expected duration of medication regime: _____

_____
Signature of Physician

If student may carry and be **RESPONSIBLE** for an **Epipen** or **Metered Dose Inhaler.**
Please initial here:

_____ Physician _____ Date

_____ Parent _____ Date

I do hereby release, discharge and hold harmless, Crestwood School District, its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

_____
Signature of Parent