RELEASE FOR ADMINISTERING MEDICATION
HOLDREGE PUBLIC SCHOOLS
HOLDREGE, NE 68949

I/We request that qualified school personnel administer medication to my child.

_____ _____ _____

(student's name) (teacher/grade) (school)

I/We absolve Holdrege Public Schools personnel and District 44 from any liability stemming from adverse reactions and all other adverse effects which may occur because of the administering the prescribed medication for my child.

Name of Medication _____

Dosage or amount to be given of medication _____

Time medication is to be given _____

Route of administration (my mouth, inhaler, etc.) _____

Reason for taking medication _____

Possible side effects _____

PRESCIPTION MEDICATION MUST BE IN THE ORIGINAL LABELED BOTTLE OR CONTAINER FROM THE PHARMACIST WITH THE CHILD'S NAME, NAME OF MEDICATION, AND DOSAGE. NON-PRESCRIPTION MEDICATIONS NEED TO BE IN THE ORIGINAL LABELED CONTAINER/BOTTLE.

_____

(Parent/Guardian Signature) (Date)