

REQUEST AND RELEASE

Administration of Medication by Norman Public School Personnel
Parent/Guardian and Physician's Statement

The undersigned hereby requests the Norman Board of Education by and through such teacher or other school personnel as may be designated by the Superintendent of Schools to administer the medication hereinafter described to the child hereinafter named, of which I have legal custody.

I understand this form merely reflects the request that the hereinafter named student be administered certain medication and that Norman Independent School District No. 29 agrees to cooperate if possible. I further understand that Norman Independent School District No. 29 does not, in any way, guarantee that the medication will be administered to the hereinafter named student. I hereby release Norman Independent School District No. 29, its officers and its employees, from any and all liability resulting from its failure to administer the medication indicated below. I further hereby release Norman Independent School District No. 29, its officers and its employees from any and all responsibility for adverse effects of this medication and agree to indemnify them, or any of them, against any and all liability, loss or damage they or any of them may incur as a result of giving or not giving the medication.

I agree to provide to the Norman Public Schools a signature of the child's physician directing the administration of any prescription medication and verifying all particulars connected with such administration. I agree to provide all such medication at my expense at such times and places as you may require. I further agree that, in the event of any change in the health or condition of the child, I will promptly notify you and advise whether there is to be any change in the administration of such medication. I further agree that, in the event of a change of physician for the child, I will obtain from the new physician a new written statement concerning administration of prescription medication to the child.

NAME OF CHILD _____
ILLNESS OR CONDITION _____
NAME OF PHYSICIAN _____
NAME OF MEDICATION PRESCRIBED _____
SIZE OF DOSE _____
NUMBER OF TIMES IN SCHOOL DAY TO BE ADMINISTERED _____
TIME OR TIMES OF ADMINISTRATION _____
TO BE ADMINISTERED UNTIL (DATE) _____
DATED THIS ___ DAY OF _____ 19_____
Parent/guardian

*Form must be signed by (1) either parent, if both parents have legal custody; or (2) the parent or other person having legal custody; or (3) the legal guardian.
I have reviewed the above request for the administration of medication to the child therein named and confirm that it is correct.
Contraindications which, if observed, require cessation and further directions from the physician, are as follows:

Additional Instructions: _____

Signature of Physician (REQUIRED if prescribed medication)