

Parent Release for the Administration of Over the Counter Oral Medication or Medical Procedures at School

To the Principal of:

- | | |
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| <input type="checkbox"/> Central Elementary | <input type="checkbox"/> Reading Middle School |
| <input type="checkbox"/> Hilltop Elementary | <input type="checkbox"/> Reading Senior High School |

We (I) the undersigned who are the parent(s) guardian(s) of _____ request that oral medication or procedures be administered to our child. We (I) understand that the administration of said medication or medical procedure is to be done under the supervision of a member of the school staff.

Further, we (I) understand that the school personnel may not be legally obligated to administer oral medication or medical procedures to any child, and therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or medical procedures or the manner in which they are administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

Further, we (I) will notify the school immediately if we change medication or terminate the use of this medication for any reason.

Notes:

- MEDICATION MUST BE RECEIVED BY THE SCHOOL IN THE ORIGINAL PACKAGING.
- ALL MEDICATION MUST BE TURNED IN TO THE SCHOOL OFFICE

Medication _____

Amount _____ How Often _____

Reason for Medication _____

Signature of parent/guardian _____ Date ____ / ____ / ____

Address of parent/guardian _____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____

Cell Phone (____) ____ - ____