Parent Release for the Administration of

Over the Counter Oral Medication or Medical Procedures at School

To the Principal of:

- ☐ Central Elementary
- ☐ Hilltop Elementary
- ☐ Reading Middle School
- ☐ 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 ay 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 (____) _____-________