Jefferson County Public Schools (JCPS) 2016-2017

<u>Authorization to Give Prescription Medication</u>

Student:	Date of I	Birth:	
	School `		
	4 P.11. G.1. 14	1 1 1	
I hereby request Jefferson Count that has been prescribed by	ty Public Schools personnel to give th	ie above named studei	nt medication
Date of last office visit:	•		
	phone no.: Fax	no	
Health care provider's addr	ress:	. 110.	
Date to start medication:	ress: Date to s	ston medication:	
Reason medication is neede	ed:	nop medication:	
Reactions/side effects:			
1. Name of medication:	child this medication (these must mate		·
	ge (i.e. 8:00am, 1:00pm, etc.):		
	(i.e. mouth, nose, eyes, ears):		
5. Special instructions (i.e.	take on empty stomach, crush, sprinkle	e):	
trained, unlicensed JCPS personnel sponsored field trip this medication parent/guardian acknowledges that incur no liability as a result of any the injury is the result of negligence parent/guardian shall hold harmless any medication or the administration behalf of the school or its employed.	nedication is not self-administered, it w l. I acknowledge and agree when I auth in may also be administered by a license to the Jefferson County Board of Educati injury sustained by the student from an see or misconduct on behalf of the school is the school and its employees against a on of such medication unless the reaction by easy. Also, I hereby give permission for information with JCPS and to consult y	orize my child to attended volunteer. By signing ton, its employees and a y reaction to any medical or its employees. The any claims made for an on is due to negligence for the health care proving the second of t	d a school g this form, the agents shall cation, unless e ty reaction to or misconduct ider completing
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Telephone #	Date
Emergency Contact	Relationship	Telephone #	

Equal Opportunity/Affirmative Action Employer Offering Equal Educational Opportunities