



**SEAMAN UNIFIED SCHOOL DISTRICT #345
REQUEST AND AUTHORIZATION TO ALLOW MEDICATION AT SCHOOL**

NAME OF STUDENT _____

MEDICATION _____

DOSAGE _____ **Time of Day Medication is to be taken** _____

Anticipated number of days needed at school _____

Purpose of Medication _____

I hereby request and give permission for the above named student to take the medication as indicated above. I understand this form merely reflects the request that the student named above be allowed to take medication at school and that Seaman School District #345 acknowledges this request and agrees to comply with the request if possible. I understand that Seaman School District #345 does not, in any way, guarantee that the medication will be taken by the student named above. I further hereby release Seaman School District #345, its officers and employees, from any and all responsibility for adverse effects of the medication and agree to indemnify them against any and all liability, loss or damage they or any of them may incur or suffer as a result of observing or not observing the taking of the medication by the student named above.

I hereby authorize Seaman School District #345 Registered Nurses to exchange information regarding this request with the prescribing physician and with the pharmacy as identified on the affixed pharmacy label if clarification is required.

(Date)

(Parent or Legal Guardian)

(Date Registered Nurse Notified)

(Registered Nurse Notified by)

(Registered Nurse Initials)