Payson Unified School District #10

CONSENT AND RELEASE FOR STUDENT TO CARRY/SELF ADMINSTER MEDICATION

Campus: _____ **Grade:** _____ **School Year:** _____

Student Name: _____ **Date of Birth:**_____ **M / F**

I, _____ (parent/guardian name) have instructed my above named child in the proper purpose and appropriate method and frequency to use the following _____, _____, _____ medication(s). I request that my above named child be permitted to carry the prescription on his/her person. I, the parent/guardian absolve the School District of liability if the medication is lost, stolen, or abused in any way by the student.

We further note that:

1. The above-named student understands his/her responsibilities for keep the medication safely on his/her person. The above-named student understands the importance of preventing other students from using the medication, and that such use could seriously endanger other students. As a parent I have discussed these issues with my child and I believe he/she understands his/her responsibilities for safe medication use.

2. As a parent, I understand that as a result of losing his/her medication, my child is at risk for a more serious crisis.

3. The child/student and his/her parents understand that the usual policy of the Payson Unified School District is to keep all medications locked in the school health center, for the protection of all students.

4. I understand that the school is not responsible to assist, oversee or supervise my child in the administration of the prescribed medication.

_____ _____ _____

Parent Signature Parent Signature Date

_____ _____

Student Signature Date

_____ _____

School Nurse or Health Specialist Signature Date

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