

Request for Administration of Prescription Medication By School Personnel

(This form expires at the end of the current school year.)

Student Name	Date of Birth	School Year	Grade
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As this student's parent/guardian, I give permission for my child to receive the following medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

Prescription Medication	Circle	Dosage/Puff	Time/Frequency
Daily Maintenance Inhaler	Yes		
Emergency Inhaler	Yes		
EpiPen	Yes		
Other:	Yes		

Physician's Signature Required (or a copy of this prescription must be attached to this form)

Special Instructions:

Possible side effects to watch for include: _____

Is this student allergic to any medications? ___ No ___ Yes, allergic to _____

I give permission to any trained Cincinnati Waldorf School staff member to give my child the above-mentioned medications. I further agree to indemnify or hold harmless the Cincinnati Waldorf School and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information. Please note, the parent or guardian must provide **two** inhaler/EpiPen/other emergency prescription medication, one to be kept in the office and the other to be self-carried by the student or the class teacher.

Signature of Parent/Guardian

Date

Please Print Name of Parent/Guardian