HILLEL ACADEMY

PARENT REQUEST AND RELEASE FOR THE ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

TO:_____Principal DATE:_____

FOR:_____ _____
(Student's Name) (Grade)

We (I) the undersigned who are the parent(s), foster parent(s), guardian(s), (cross out those not applicable) of _____(Student's Name) request that oral medication be administered to our child in accordance with the instructions of our physician,
Dr._____.
We (I) understand that the administration of said medication is to be done under the supervision of a member of the school staff.

We request that the following medication(s) be given as directed:

_____ Dosage:_____ Time:_____

_____ Dosage:_____ Time:_____

_____ Dosage:_____ Time:_____

Further, we (I) understand that the school personnel are not legally obligated to administer oral medication to any child and therefore, we (I) agree to hold the School District, the Combined Health District and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them. Further, we (I) will notify the school immediately, if we change physicians or medication or terminate the use of this medication for any reason.

** Signature of Father_____** Signature of Mother_____

Cell#_____ Cell#_____

Home#_____ Address:_____

This form is required under Ohio Law S.B. No. 262

****Both parents must sign this release if they are living with or have custody of child. If parents are separated and both still retain legal custody BOTH parents must sign. If children are in foster home and placements is by agency that holds custody, agency must sign.**