

Parental Request for Assistance in Administering Drugs

Name of Pupil _____

Medical Condition _____

Medication Prescribed _____

Dose/ Instructions _____

I certify that the information given above is correct. I authorize the school to be responsible for the administration of drugs to the above named pupil. I understand that the drugs will be administered by the Office Manager, or Principal or his / her nominee.

I understand that Rukuhia School Board of Trustees or Staff will accept no liability for any adverse effects from the dispensing of medication.

I understand that Rukuhia School Board of Trustees or Staff accepts no liability for any student who refuses to take their medication.

Parent/Caregiver's Signature

Date