



PRESCRIPTION MEDICATION FORM

I authorize school personnel to administer to the student the prescription medication listed below (please complete a separate form for each medication):

Prescription Medication: _____

Prescribing Doctor: _____

Dosage Required: _____

Dates and Time to Administer (PRN if “as needed”): _____

Additional Directions: _____

I release and agree to defend, indemnify, and hold harmless Evansville Day School, its employees, and its agents from any and all loss, liability, costs, attorney fees, or claims (including claims of the student) arising from or related to the administering of the prescription medication listed above.

Signature of Parent/Guardian Contact Phone# Date

I authorize school personnel to administer to the student the prescription medication listed below (please complete a separate form for each medication):

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Prescribing Doctor: _____

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