PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

To Parents or Guardian: In order to request that Summit School administer medication to your child at school, the following is required:

- The medication is furnished by the parent(s) or guardian in a container labeled by the pharmacist or physician with:

  Name of child — Name of medication — Conditions for proper storage
  Name of physician — Dosage, route and time — Prescription date and expiration date

- The Covenant not to Sue and Indemnification Agreement signed by both parents or guardians.

We,_____, being over 21 years of age, parents and/or guardians of_____, a minor of _____ years of age, in accordance with physician's order (below), on file with The Summit School, its agents, servants and employees, promise that neither said minor nor we, individually or as parents or guardians of said minor, will ever institute any suit for damages, loss or injury either to person or property or both, whether developed or undeveloped, resulting or to result, known or unknown, which said minor or we individually, or as parents or guardians of said minor, now have or which we, our or his heirs, executors or administrators, hereafter can, shall or may have for, on or by any reason of any matter, cause a thing whatsoever. And in further consideration of said services made to us, individually and on behalf of said minor, we hereby agree to indemnify and save harmless The Summit School, its agents, servants and employees against any claim for damages, compensation or otherwise on the part of said minor or his heirs, executors or administrators, and to reimburse or make good any loss or damages or costs that they may have to pay in any litigation that arises on account of any claim made by said minor or anyone on his behalf.

In witness, whereof, we hereunto set our hands and seals this _____day of_____, 20_____.

Parent or Guardian:_____

- The child's physician must complete the Physician's Signed Order below. ‘’

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL

Name of Student_____DOB_____
Diagnosis_____
Name of Medication_____
Dosage_____(mg, ml, ml/tsp,# of puffs)
Route_____Time of administration at School_____
If PRN, for what symptoms?_____
How often?_____
Please list any specific precautions personnel should be aware of or any unusual effects that might be observed:_____
_____
Services should begin (date)_____ and terminate (date)_____

FOR INHALER and EPI-PEN MEDICATION ONLY:

☐ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-Pen and has been trained in its use including knowing when the medication is to be used.

☐ This student should not self-administer inhalant medication or Epi-Pen.

Physician's signature_____
Physician's name (printed)_____
Address_____St_____Zip_____
Telephone number_____ Date_____

We assure that the first dose of this medication has been given without problems and having read the above conditions, we request that The Summit School administer the medication as prescribed by the physician above to our child_____.

Parent/Guardian_____

Parent/Guardian_____

Both parents (or guardians) must sign or indicate the reason a signature is not available (such as a deceased parent).

Parent's telephone number_____