METROLINA REGIONAL SCHOLARS ACADEMY

Permission to Administer Student Medication 2018-2019

I hereby give permission for my child _____
Child's Full Name

to receive medication during school hours. I release Metrolina Regional Scholars Academy and its agents and employees from all liability that may result from my child taking the medication as prescribed by a licensed physician, or from taking over-the-counter medication that I have authorized my child to take.

This consent is good for the current school year, unless revoked.

I will furnish **all prescription medication in its original container**, and all over-the-counter medication in a container clearly labeled with my child's name. I know that if I do not pick up this medication at the end of the school year, it will be discarded.

Here is the list of medications I am authorizing:

Date (when medication is dropped off)	**Medication**	**Reason/Purpose**	**Dosage**	**Frequency/when to Administer**

Please list any allergies or special needs your child has or specific instructions for the medications above:

_____

_____

_____

_____

_____ _____
Parent Guardian Signature Date