ALLEGHENY – CLARION VALLEY SCHOOL DISTRICT

PARENT CONSENT FOR PRESCRIPTION MEDICATION

I request that the school nurse or substitute nurse administer this prescribed medication to my child according to the directions from our prescribing physician.

As a parent/guardian of _____, I hereby release the Allegheny-Clarion Valley School District and all its employees from any and all liability for damages my child may suffer as a result of this request.

_____ _____

Name of Doctor Date of Prescription

_____

Name of medication and dosage

_____ _____

Signature of Parent Date