AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AND WAIVER AND INDEMNIFICATION FROM LIABILITY

The undersigned parents/guardians ("Parents") hereby authorize the Rockwood School District ("District") to allow the Parents' child named below ("Child") to self-administer the medication(s) stated below ("Medication"), and represent to the District that the history stated below of the child's experience with the illness being treated by the Medication is accurate and complete. The Parents also authorize the District to implement the plan of action stated below for addressing any emergency situation which may arise as a consequence of the Child self-administering the Medication. **The signed original of this form must be on file with the school nurse. Medication must be carried in its original labeled container whether prescription or over-the-counter.**

The District hereby notifies the Parents that neither the District, its employees nor its agents shall incur any liability as a result of any injury arising from the self-administration of the Medication by the Child, and the Parents hereby acknowledge that no such liability shall exist, and on behalf of themselves and the Child hereby waive any such liability. Furthermore, the Parents hereby agree to indemnify and hold the District, its employees and its agents harmless against any claims whatsoever arising out of the self-administration of the Medication by the Child.

Name of Child: _____

Medication(s): _____

Medical History: _____

_____

_____

_____

Emergency Plan of Action: _____

_____

_____

_____

For School Year: _____ (**MUST BE RENEWED ANNUALLY)**

Signatures:

_____ _____

Parent/Guardian Date Physician Date

PHYSICIAN'S SIGNATURE IS REQUIRED.

_____

School Nurse Date