Authorization for Administration of Medication

I give permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at pilotED Schools to administer my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, medication, to share information relevant to the prescribed medication, to determine if self-administration of medication is safe and appropriate for my child’s health, and to allow self-administration of medication.

I understand that medication may be destroyed if it is not picked up within one week following the termination of the order or one week beyond the end of the school year. I hereby release pilotED Schools, its staff members, and its officers from liability associated with administration of my child’s medication and/or with medical treatment for my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date