# AUTHORIZATION TO DISPENSE MEDICATION

SCHOOL YEAR: 2024-2025

**Family Last Name** (Please Print Legibly)**:** _____

| STUDENT FIRST NAME | STUDENT LAST NAME (IF DIFFERENT) | GRADE |
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**PCS MEDICATION POLICY**:

- All students needing medication must go to the nurse to receive it.
- Families with students who need medication agree to provide it to the nurse in their original (new), properly labeled containers. (Medicines may not be shared with anyone outside of the family.)
- Medicines will only be dispensed to those students with a signed Authorization to Dispense Medication on file.
- OTC medications will be dispensed per the manufacturer's dosage instructions according to the student's age/weight unless otherwise prescribed by a physician.
- Prescription medications must be in the original container and will be dispensed per instructions on the pharmacy label.
- The nurse may contact the pharmacy or prescribing physician for clarification if needed.

_____ I authorize any adult designated by Administration to dispense medications to my child provided the medication has been supplied by our family per the PCS medication policy.

_____ I understand that herbal medications, home remedies, or dietary supplements will not be dispensed without written authorization from my child's physician. If these are dispensed, they must come to school in a new, labeled, and original container.

_____ I understand that my child may not self-carry medication unless a physician's consent is on file and the student has demonstrated proper administration of the medication to the school nurse (requires a medical action plan). Permission to self-carry may be revoked if the school nurse/administration has reason to believe that the medication is being used inappropriately.

_____ I understand that my child must go to the nurse for all medication.

_____ I understand that if the medication or dosage is changed or terminated I will notify the school immediately.

WAIVER OF LIABILITY

I understand that this request is effective for the school year in which it is granted and must be renewed each subsequent year.

I acknowledge that the school and its agents shall incur no liability as a result of harm or injury arising from the dispensing of medications provided by me. Further, I acknowledge that the school and its agents shall incur no liability as a result of harm or injury arising from the dispensing of medication per written instructions from my child's physician, prescription label, or manufacturer's dosage recommendations. I hold harmless Providence Classical School and its employees or agents against any claims.

Parent/Guardian Signature: _____ Date: _____