PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL

I request that York City School District and/or Holy Trinity School personnel administer this prescribed medication to:

_____ according to directions from _____.
(Student's Name) (Physician' Name)

I, hereby, release the School District of the City of York, Holy Trinity School and all their employees from any or all liability as a result of this request.

The medicine is to be furnished by me, and is to be in the original container. Container is to be labeled with the name of the medicine, amount to be given, time of day to be taken, duration of treatment and physician's name.

_____
(Signature of Parent/Guardian)

Name of medicine:_____

Date:_____ Dosage:_____

School:_____

Time of Day Given:_____ Reason:_____

York City - SN-57