



**UPLAND COUNTRY DAY SCHOOL**

**AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS**

\_\_\_\_\_ must receive the following  
Full Name of Student

PRESCRIBED MEDICATION during school hours in order to maintain sufficient health to participate in the school program:

Name of Medication \_\_\_\_\_

Prescribed Dosage \_\_\_\_\_

Time Schedule \_\_\_\_\_

Length of Time (Days/Weeks) \_\_\_\_\_

**Reason for Administration \*** \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Medical Practitioner

I do hereby release, discharge, and hold harmless, the Upland Country Day School, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

\_\_\_\_\_  
Signature of Parent/Guardian

**\*Emergency medications, i.e. inhalers and Epi-pens may be carried by school age students with parent's and medical practioner's permission.\***

\_\_\_\_\_ has permission to carry and self-administer  
Full Name of Student this prescription medication.

\_\_\_\_\_  
Signature of Parent/Guardian                      Date

\_\_\_\_\_ has demonstrated the ability and is qualified to  
Full Name of Student safely self administer this prescription medicine.

\_\_\_\_\_  
Signature of Medical Practitioner                      Date