

**WINTON WOODS CITY SCHOOLS
MEDICINE RELEASE FORM**

All medications must accompany this form, must be in the original container, and must be delivered to the school by an adult.

THIS SECTION TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN
Use separate form for each medication

Student's Name: _____ Bldg: _____ Grade: _____ Teacher: _____

Medication: _____ Dosage: _____

Time(s) to be given _____ (e.g. lunchtime, 12:00PM, etc.)

Description of Medication: _____

Possible side effects: _____

In signing this form, I will assume responsibility for safe delivery of the medication to the school, I will be responsible for providing written notification by myself and my physician of any change in the use of the medication or the prescribed treatment, and I release and agree to hold the Board of Education, its employees and its officials harmless from any and all liability foreseen or unforeseen for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Emergency Phone: _____

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THIS SECTION TO BE COMPLETED BY PHYSICIAN FOR PRESCRIPTION MEDICATIONS*
Use separate form for each medication

Student's Name: _____ Bldg: _____ Grade: _____ Teacher: _____

Medication: _____ Dosage: _____

Time(s) to be given _____ (e.g. lunchtime, 12:00PM, etc.)

Description of Medication: _____

Possible side effects: _____

Special instructions: _____

Physician's Name: (print) _____ Phone: _____

Physician's Signature: _____ Date: _____

Date of initiation of medication: _____ Date to discontinue: _____

This permission is valid only for the current school year.

If a student is to have a medication in his/her possession, it must be so ordered, in writing, by both the physician and parent.