AUTHORIZATION FOR STUDENT TO CARRY PRESCRIPTION Diastat or Valtoco

In my medical opinion, it is necessary for _______ to carry Diastat. (It is preferable that additional Diastat be kept in the clinic in case the first is lost or left at home.)

Medication Dosage and Directions

Licensed Health Care Provider's Signature & Stamp

I will not allow another student to use my medication under any circumstances. I also understand that I will be subject to the consequences of the code of conduct should another student use my prescription.

Date

Student's Signature

Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse the Paulding County Board of Education, the Paulding County School District, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Paulding County School District and its employees of any legal responsibility when the above named student administers his/her own medication.

Parent/Guardian Signature

Date

Rev. 3/8/07

