EUFAULA PUBLIC SCHOOLS
PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE

TO: Name of Administrator: _____

Name of School District: _____

Name of School Site: _____

I am the parent, guardian, or legal custodian with legal custody of _____, a minor student attending this school. This student requires medication at intervals during the school day.

I hereby give my consent and authorize the school nurse, the principal, or their designee (an employee of the school district designated by the school nurse, the principal, and me) to administer:

☐ any non-prescription medication and/or prescription medication which I am hereby supplying you in accordance with the directions for administration of the medicine which is attached hereto

☐ I hereby give my consent and authorize my child to self medicate under the School District's Policy on the Administration of Medicine to Students.

☐ I understand that under state law the Board of Education, the School District, or employees of the district shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

☐ I agree to abide by all of he terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

Date: _____

Signature: _____

_____
Name of Parent with Legal Custody or Guardian - Please Print

_____
Complete Address - City State Zipcode