



Permission to Administer Medication

I give permission for my student to be given the following medication:

Student's Name: _____

Name of Medication: _____

Medication Expiration Date: _____

Dosage: _____ Refrigerate

Dates to be Given: _____

Times to be Given: _____

Special Instructions: _____

Possible Reactions: _____

By signing this form you are giving expressed permission for a staff member of Quad Cities Christian School to administer the medications listed above. The school and school personnel will not incur any liability for injuries occurring when administering asthma medication, an epinephrine auto-injector, or an opioid antagonist.

Quad Cities Christian School requires, as a condition to its agreement to release any prescription or over-the-counter medication, that the medicine be prescribed by a healthcare provider, physician assistant (PA), or advanced practice registered nurse with prescriptive authority and furnished by the parent(s) of the student with the original pharmacy container label stating the student's name, name of medication, the dosage, the number of dosages per day or time(s) when the medication is to be released to the student, and the date when the medication is to be stopped (if applicable). It is understood that the medication is given solely at the request of, and as an accomodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s) or guardians(s) hereby agree to release Quad Cities Christian Schools and its personnel from any and all claim(s), which they now have or may hereafter have arising out of the release of the medication to the student.

Parent Signature: _____

Date: _____