Medication Plan, Parent Request, and Waiver of Liability

I am unable to arrange a dose schedule that avoids school hours, and I therefore request that my student be permitted to take medication at school. I give permission for the school to assist my student, as needed, in taking medications. I understand that The Circle School does not have a nurse or other medical practitioners at school, and the school's staff members are not medically trained. I understand the school will apply ordinary diligence and care in assisting my student with medications.

Student's name: _____

This plan will be in effect (mm/dd/yy): ☐ from _____/_____/_____ through _____/_____/_____.

– OR –

☐ until further written notice from me.

Check one: ☐ There is no need to keep a record of each time my student takes medication under this plan.

☐ I prefer a record to be kept, and I understand the school will assist my student in filling out the medication log, as needed.

LIST ALL MEDICATIONS COVERED BY THIS PLAN

Name of Medication	Note

I confirm that I am providing all of the following for each medication listed above: (1) medication in its original container; (2) current prescription, if a prescribed medication; and (3) student's name on container.

On behalf of myself, the student, and all who represent our interests now and hereafter, I hereby release and agree to hold harmless The Circle School and its staff members and all others acting for the school, against any claim or cause of action for any injury to the student caused by or connected with this medication plan and this medication.

_____ _____

Parent Signature Student signature

_____ _____

Date Date

FOR SCHOOL USE. Received by / date:

Medication Log

Name of Medication	Dose Taken	Time Taken	Date Taken	Safety Check *	Initials	Comments

* Administration matches medication plan (5-point check: right med, dose, patient, time, route)