Parent/Guardian Medical Procedure Request/Waiver

Name of Student_____ AB Health Care # _____
(optional)

Birthdate_____Home Telephone_____

Address _____

Emergency Contact Name & Telephone _____

Medical Condition _____

** Procedure Required: (Indicate specific details)_____

Name of Doctor _____ Doctor's Telephone _____

Name of Medication _____

Pharmacy_____ Pharmacy Telephone _____

The time(s) medication/procedure is to be given _____

Dosage and/or related instructions _____

Possible side effects _____

Special procedures or instructions

☐ We, the parents/guardians of _____ request the procedures identified above and hereby release and indemnify all rights of action on behalf of ourselves and/or our child in case of any cause of action that may arise as a result of proceeding with our request for administering medication or medical procedure.

OR

☐ We, the parents/guardians of _____ exercise our right NOT to provide an adequate supply of up-to-date auto-injection or other prescribed medications.

Parent/Guardian _____ Date_____

Parent/Guardian_____ Date_____

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SCHOOL USE

Location where medication/personal or care supplies are kept

Person designated to administer or provide procedure _____

Alternate person(s) _____

**Where procedures beyond a written prescription are required, written instructions from the doctor shall be attached.