ALPHA ACADEMY
MEDICAL AUTHORIZATION AND RELEASE

Please note: This form is to be completed <u>only</u> for prescribed medications. Prescriptions submitted to the school office must be accompanied by the original prescriptive package.

Student Name ____ Date of Birth________________

Address ____

School_________________________________ Teacher(s)________________________________

Father's Name ______________________________________ Work ______________________

Mother's Name _____________________________________ Work ______________________

Guardian's Name ___________________________________ Work ______________________

If both parents are unavailable, name of person to contact:

Name ____ Phone _______________________

Name of Physician who prescribed the medication _______________________________________

Office Phone _______________________________________

Schedule for administering of medication (attach instruction from physician if more room is needed.)

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Special Instructions:

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The undersigned hereby releases and agrees to hold harmless and indemnify Alpha Academy. Its employees, State Board of Education of North Carolina, and the Board of Directors from any liability whatsoever occasioned by the administration or non-administration of the above described medication to you child during school hours in accordance with the above instruction.

The undersigned also authorized the prescribing physician needed above to discuss with the principal or is/her designated staff member any matter regarding the medication to be administered.

____ ______________________

Parent Signature Date

____ ______________________

Physician Signature Date