MAINE COAST
WALDORF SCHOOL

PERMISSION & RELEASE: Administration of Medication

This Permission and Release applies to Maine Coast Waldorf School Officials, Staff, Coaches, Volunteers and Other Representatives during school and in connection with school activities[1]

Each Medication Requires a Separate Form

Student Name: _____ DOB: _____

Student's Grade: _____ Teacher: _____

Name of medication: _____

Reason for medication: _____

Type of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other _____

Instructions during school day:

Dose: _____ Frequency: _____

Start date: _____ Stop Date: ☐ End of school year

☐ Other date/duration: _____

Special instructions or important side effects: ☐ None ☐ Yes, please describe below:

_____

_____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

The administration of this medication during the school day is necessary for the student's health and attendance in school. It is recommended that the first dose of a newly prescribed medication be given at home.

This student has the knowledge and skill to carry and self-administer this medication (epi-pens/inhalers/insulin only) ☐ Yes ☐ No

Name of Health Care Provider: _____

Signature of Health Care Provider: _____

Phone number: _____

[1] School activities include activities offered by the school before during and after school, as well as on the weekends and during summer and vacations, as well as any travel and transportation associated with the activities. They include, but are not limited to, field trips extracurricular activities, athletic programs, school-wide outings, student competitions and school fairs and celebrations.

Permission & Release:

I am not available to dispense the above named medication during school hours and/or while the student listed above is participating in a school activity. I understand that this will be administered by non-medical personnel, volunteers, and/or other representatives of the Maine Coast Waldorf School (hereinafter "MCWS"), and give my permission for the medication to be given to the student named above. Information regarding the medication may be shared with appropriate personnel volunteers, and/or other representatives of MCWS.

I further understand and agree to the statements below:

1. ALL medication must be brought in to school by the parent or guardian in the original labeled prescription bottle. (Pharmacy will provide an extra labeled container, if needed). Respiratory inhalers and EpiPens may be carried by the student.

2. MCWS reserves the discretion to reject any requests for medication administration.

3. MCWS medication policy is in our school handbook. Required forms will be provided to parents upon request.

4. MCWS disclaims any and all responsibility for the diagnosis, prescription, and treatment pertaining to medication administration including side effect.

5. I agree on behalf of myself, the student named above, as well us on behalf of our heirs, successors and assigns, to hold harmless and defend MCWS, its officers, staff, directors and agents, coaches, chaperones, volunteers, and other representatives from any and all actions, claims, demands, damages, costs, expenses and all consequential damage arising from or in connection with the administration of medication to the student listed above, and I agree to compensate MCWS, its officers, staff, directors and agents, coaches, chaperones, volunteers, and other representatives for any and all reasonable costs and fees, including reasonable attorneys' fees, associated with any and all actions, claims, demands, damages, costs, expenses and all consequential damage arising from or in connection with the administration of medication to the student listed above.

6. I agree and understand that this permission and release form is intended to be as broad and inclusive as permitted by the laws of the State of Maine, and that if any portion of this form and/or release is held invalid, it is agreed that the balance of the form shall remain and continue in full force and effect.

Signature(s) of All Parent(s)/Guardian(s)*:

*By signing below, I acknowledge that I have read and understand this permission and release of liability form.

Name (Print)	Signature	Capacity	Date
Name (Print)	Signature	Capacity	Date
Name (Print)	Signature	Capacity	Date
Name (Print)	Signature	Capacity	Date

Permission to Contact Prescribing Health Care Provider:

☐ YES ☐ NO

I give my permission for MCWS to contact the above named prescribing health care provider to obtain information about the medication and the administration schedule. I give my permission for the school nurse consultant and/or administration to share information with the prescribing health care provider about the effects of the medication on my child's learning.

Medication Removal:

_____
(please initial)

I understand that I must remove any medication no longer required or that remains at the end of the school year or it will be disposed of.