Medication Release Form

Student's Full Name _____DOB: _____

Name of Parent/Guardian:_____

(Please read information below and initial)

___ The undersigned affirms that he/she is the legal guardian of _____ and agrees to the Logos policy that medication is **NOT** to be in the possession of the student.

___ Further, the undersigned agrees to permit the person designated by Logos staff to hold and dispense the medication listed above to the student based on the instructions found on the label.

___ Finally, the undersigned recognizes that the Logos staff member responsible for dispensing medication is not a medical doctor, nurse, nor a pharmacist; and neither such person nor Logos shall be responsible for or liable in connection with such medication dispensed.

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Medications	Dosage/Time	Prescribing Physician	Reason for medication

List any allergies or medications that should not be given_____

_____

Does your child have permission to take an over-the-counter pain medication? _____ Yes _____ No

If Yes, circle which ones: **Advil** **Aspirin** **Aleve** **Ibuprofen** **Tylenol**

_____ _____

Parent/Guardian Signature Date