



Medication Permission
(Revised 11/16)

I, _____, give my permission for Head Start designated staff to administer the following medication, _____,

Exact Amount: _____ Approximate Time: _____

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by employees designated by Head Start, the undersigned parent or guardian hereby agrees to release the Van Buren County Head Start and its personnel from any legal claim which they now have or may therefore have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for my child _____ to take the above prescription as ordered. I understand that it is my responsibility to furnish this medication.

Date: _____ Signature of parent or guardian _____

UCHRA Van Buren County Head Start
Medication Permission(Revised 11/2016)

I, _____, give my permission for Head Start designated staff to administer the following medication, _____,

Exact Amount: _____ Approximate Time: _____

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by employees designated by Head Start, the undersigned parent or guardian hereby agrees to release the Van Buren County Head Start and its personnel from any legal claim which they now have or may therefore have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for my child _____ to take the above prescription as ordered. I understand that it is my responsibility to furnish this medication.

Date: _____ Signature of parent or guardian _____

[Medication Procedure](#)