Parental Consent for Medical Treatment of Minor Ailments and Prescriptions

Name_____ Health Care Number/Province_____

My son/daughter has been diagnosed with_____ and takes the following prescribed medication:

_____
_____
_____

My son/daughter has the following allergies:

_____
_____
_____

_____ I grant permission and authorize the Dean on duty/School Administration to administer the following non-prescribed remedies.

_____ Pain relief _____ Indigestion/Gas relief _____ Nausea relief

_____Cold/Flu Relief _____Allergies

I have reviewed the medication administration procedure with my son/daughter and I understand that all medications (prescription/non-prescription) must be maintained in the original container with the original label. The Dean on duty/School Administration may examine the prescribed medication/Daily vitamin containers and confiscate any medication that is not in the original container. It is understood that some medication may need to be kept secure in the Dean's office and administered by the Dean on duty. This is to insure the safety of all dorm residents.

In consideration of this authorization the undersigned agrees to indemnify, defend, and hold harmless Parkview Adventist Academy, and its affiliated entities, the individual members thereof and any officials or employees of the school from any claims or liability for injury or damages including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused from the administration of these medications.

Parent/Guardian Signature_____ Date_____

Student Signature_____ Date_____

Witness Signature_____ Date_____