



## Parent/Guardian Medical Procedure Request/Waiver

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Name of Student \_\_\_\_\_ AB Health Care # \_\_\_\_\_  
(optional)

Birthdate \_\_\_\_\_ Home Telephone \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact Name & Telephone \_\_\_\_\_

Medical Condition \_\_\_\_\_

\*\* Procedure Required: (Indicate specific details) \_\_\_\_\_

Name of Doctor \_\_\_\_\_ Doctor's Telephone \_\_\_\_\_

Name of Medication \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Telephone \_\_\_\_\_

The time(s) medication/procedure is to be given \_\_\_\_\_

Dosage and/or related instructions \_\_\_\_\_

Possible side effects \_\_\_\_\_

Special procedures or instructions

We, the parents/guardians of \_\_\_\_\_ request the procedures identified above and hereby release and indemnify all rights of action on behalf of ourselves and/or our child in case of any cause of action that may arise as a result of proceeding with our request for administering medication or medical procedure.

OR

We, the parents/guardians of \_\_\_\_\_ exercise our right NOT to provide an adequate supply of up-to-date auto-injection or other prescribed medications.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



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### SCHOOL USE

Location where medication/personal or care supplies are kept

Person designated to administer or provide procedure \_\_\_\_\_

Alternate person(s) \_\_\_\_\_

\*\*Where procedures beyond a written prescription are required, written instructions from the doctor shall be attached.