



2025-2026 CONSENT FOR PRESCRIPTION MEDICATION

Because this form must be signed by your child's physician, it must be printed out and filled in by hand rather than submitted electronically.

PRESCRIBED MEDICATION

I hereby request and authorize the Gesher Jewish Day School personnel to administer prescribed medication to _____ (**name of student**) as directed by their physician. I agree to release, indemnify and hold harmless the Gesher Jewish Day School, staff members, or agents, from lawsuit, claim, demand, or action, etc. that may be brought against them for administering prescribed medication to this student at our request.

Parent/Guardian Signature

Date

PHYSICIAN STATEMENT

To be completed by the Physician. NO emergency or daily prescription medication will be administered without physician's written approval. Please use one form for each medication.

CHILD'S NAME: _____

Name of Prescription Medication: _____

Dosage/Time medication is to be administered during the school day:

Dosage: _____ **Time:** _____

Start Date: _____ **End Date:** _____

Reason for medication: _____

Emergency medication (if applicable): _____

Mode of contact (for allergies): _____

Potential side effects: _____

Physician's name in print

Signature

Physician's phone number

Date