Malvern Preparatory School
Health Office - Sports Medicine Department
Permission to Administer Prescription Medication

It is requested that the Malvern Preparatory School nurse, the athletic trainer or an assigned designee administer the medication indicated below

to____
(Student Name)
or

It is requested that Malvern Preparatory School permit ______________________________
(Student Name)
to self-administer an asthma inhaler, insulin or a bee sting kit.

Name of Medication_________________________________

Dosage________________ Frequency__________________

Reason for Medication_______________________________

Effective Dates__________________to_________________

Name of Prescribing Physician_________________________________

Signature of Prescribing Physician_______________________________ Date________________

Address____Telephone____________________

I/we hereby request that the medication prescribed above be administered to my son and release Malvern Preparatory School and its employees from any liability or responsibility for any injuries or damages that may result in accordance with this request.

Signature of Parent/Guardian___________________________________Date_________________

*A Certified Athletic Trainer will have specific asthma inhalers available for administration at Malvern Preparatory School on an emergency basis only.