COXSACKIE-ATHENS CENTRAL SCHOOL DISTRICT

Authorization for Another Adult to Administer Medication

To be completed by parent/guardian:

I authorize ____,

(Name of designee)

My friend, family member, household member or other relationship appropriate in accordance with Education Law §6908 to administer the following medication(s):

____

____

to my child ____,

(Student name)

at the following school sponsored event :

____.

(Name and date of event)

I acknowledge that Coxsackie-Athens Central School District will not be liable for any problems that may arise as a result of the administration of such medication by the designee.

Parent/Guardian Signature: ____Date________

Print Name____