WOODFORD COUNTY SCHOOLS

Authorization for Third Party to Act as Parent or Guardian for Medication Administration / Medical Procedures

Legal Name of Student_____ Social Security #_____

Grade_____ Date of Birth_____ Phone #_____

Name of Parent/Guardian_____

Address_____

I, the legal parent/guardian of, _____, give permission for

(third party adult's name--stepparent, grandparent, etc.) _____
to administer medication(s) to my child who is a student under eighteen (18) years of age according to standard school policy. I also give permission for this third party adult to deliver my child's medication to the school in the original container and register it in the school office per the school policy.

The medications/medical procedures I am allowing the third party to administer are listed below:

_____

_____

_____

_____

By signing this form, the parent/guardian or eligible student hereby authorizes school personnel to allow the third party to act in place of the parent for the sole purpose of administering medication to my child. This release shall remain in effect until it is revoked in writing by the parent or guardian who has given the third party rights.

_____ _____
Signature of Parent/Guardian (if under 18) Date

_____ _____
Signature of Third Party Date

_____

Notary _____ State at Large

Date _____

My Commission Expires_____