

**Department of Defense Education Activity**

**John H Russell Elementary School**

**HOLD HARMLESS LETTER**

*(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)*

**PRIVACY ACT STATEMENT**

AUTHORITY: 44 USC 3101. PRINCIPAL PURPOSES: (1) To provide necessary information to authorized individuals to assist them in their administering of medication to your child in accordance with your instructions and the instructions of your child's physician; (2) To provide written assurance to said authorized individuals that they will not be held responsible for any harm or injury suffered as a result of the administering of medication in accordance with your instructions and the instructions of your child's physician. ROUTINE USES: This form will be included in your child's school health record and will not be released outside DOD channels. DISCLOSURE: Voluntary. The information requested on this form is needed to insure safe administering of medication to your child. Failure to provide the information may constitute grounds for refusal to provide the service requested by you.

We, the parents/guardians of \_\_\_\_\_, wish to advise you that he/she is under the care of Dr. \_\_\_\_\_ for \_\_\_\_\_ and that the physician has furnished medication together with written instructions for administering the medication to alleviate this condition. The medication, physician's instructions, and times for administering the medication are as follows (**one medication per form**):

**PHYSICIAN'S INSTRUCTIONS TO SCHOOL PERSONNEL**

**To be completed by physician:**

Due to the nature of the medication and/or the child's condition, it is necessary that the medication listed below be administered during school hours.

Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ School: \_\_\_\_\_

Diagnosis/Indication for Medication Administration: \_\_\_\_\_ Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time: \_\_\_\_\_ Route: \_\_\_\_\_ Duration: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Precautions/Restrictions: \_\_\_\_\_

Other Medications Taken: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Clinic:**

\_\_\_\_\_  
**Phone**

**To be completed by parent/guardian:**

I am delivering to you the medication and physician's written instructions and request this medication be given to my child in accordance with the above instructions. I fully understand that you are under no obligation whatsoever to administer the medication but will only be doing so as my agent acting on my behalf specifically and solely for this purpose.

I agree to hold you, the school, its offices, agents, and employees harmless in administering the medication. I further agree to notify you promptly when it is no longer necessary to administer this medication.

I hereby give my permission for \_\_\_\_\_ to receive, from the school nurse and/or other trained school personnel, the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. I give permission for the school nurse and health care providers at the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed, and my child's response to the medication.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

Parent daytime phone number #1 \_\_\_\_\_, #2 \_\_\_\_\_, #3 \_\_\_\_\_

Parent e-mail address \_\_\_\_\_

Home address \_\_\_\_\_

**NOTE: The prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage, and current date. The medication will remain at school for the duration of the prescription.**