

Baldwinsville Central School District

Parent/Guardian Authorization of Another Adult for Administration of 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):

Name of Event: _____

Date of Event: _____

I acknowledge that the Baldwinsville 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: _____