



PORT WASHINGTON-SAUKVILLE SCHOOL DISTRICT

We educate all children to reach their greatest potential.

Brian Sutton
Director of Student Services

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Mel Nettesheim
Interim Superintendent of Schools

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Release Form for Self Carry of Medications

Date: _____ School: _____

_____ has been instructed in the proper use of the
(Student's Full Name)

following prescribed medication: _____
(Name of Medication(s))

We, _____ and _____
(Medical Provider) (Parent/Legal Guardian)

request that _____ be permitted to carry this medication on
(Student's Full Name)

his/her person, and to take it as he/she has been instructed, as we consider him/her able to accept such responsibility. **He/she has been instructed in and understands the purpose and potential side effects of his/her medication(s).**

We, the undersigned professional medical provider and parent/legal guardian absolve the Port Washington Saukville School District and its employees, agents and officers of any responsibility in safeguarding this child's medication(s).

(Medical Provider's Signature)

(Date)

(Parent/Legal Guardian Signature)

(Date)

