SAMPLE ONLY- DO NOT FILL OUT

Medication Administration Waiver

Student Name: _____

Date of Birth: _____

Student ID #: _____

Prescribed Medication: _____

Prescribing Provider Name: _____

I, _____, acknowledge and agree to the following regarding the administration of the above-listed medication by the Davison Health Center:

1. I understand that this medication has been prescribed by an outside provider who is not affiliated with the Davison Health Center.
2. I understand that the Davison Health Center is providing administration of the medication only and is not responsible for managing my medication schedule, including missed doses.
3. I acknowledge that if the medication is not stored at the Davison Health Center, I am solely responsible for ensuring proper storage and handling in accordance with the manufacturer's guidelines.
4. I understand that I am responsible for monitoring the expiration date of the medication and replacing it as needed.
5. I understand and agree that the Davison Health Center is not responsible for any adverse effects, complications, or outcomes associated with the prescribed medication.
6. I acknowledge that in the event of a medical emergency or serious adverse reaction, the health center staff will provide appropriate care and emergency intervention.
7. For all other concerns, side effects, or questions about the medication, I agree to contact the original prescribing provider directly.

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined above.

Student Signature: _____

Date: _____

Parent/Guardian Signature (students under 18 only): _____

Date: _____

Health Center Staff Witness: _____

Date: _____

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Rev. 08/2025