Bedford County Public Schools

Providing and Administering Oral Antihistamines in School Clinics

I give permission for my child_____ to receive oral antihistamines during the school year in case allergic reaction symptoms appear. This is for emergency use only, not to treat my child's seasonal allergy symptoms. My signature testifies that my child has taken this medicine before and is not allergic to oral antihistamines.

Parent/Guardian
Signature_____Date_____

I do hereby, on behalf of myself and my child, waive any and all claims that I may have now or in the future of every kind and nature, for damages or injuries of any kind, relating to or arising out of administration of medications by school personnel.

Parent/Guardian
Signature_____Date_____