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 <u>emergency</u> use only, <u>not</u> to treat my child's seasonal allergy symptoms. I realize my child will not be allowed to drive home after receiving this medication. 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 _____