

# West Chester Area School District

## Parent Delegation of Medical Authority

I am the parent of \_\_\_\_\_, whose date of birth is \_\_\_\_\_. My child is diagnosed with \_\_\_\_\_ and is under the treatment of \_\_\_\_\_, M.D., who has prescribed \_\_\_\_\_. My child is responsible for self administering. My child is of sufficient competence and maturity to understand and to implement this regimen as prescribed per the West Chester Area School District's medication policy. I hereby delegate to the West Chester Area School District and its designated employees and agents my authority as parent and legal guardian of my child to authorize the self administration of his treatment regimen during the school-sponsored trip to \_\_\_\_\_ on \_\_\_\_\_. I understand and accept that a school nurse will not be present at any time during this activity and the teacher in charge will be responsible for the medication before and after my child self administers it.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Printed or typed name of parent