

PERMISSION FOR MEDICATION

Name of student: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Date Medication Started: \_\_\_\_\_

Time of day Medication is to be Given: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

I hereby give my permission for \_\_\_\_\_ to take the above prescription at school as ordered. I understand that any School employee who administers any drug to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of administering such drug.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

NOTE: Prescription medication is to be brought to school in the original container, appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage, and times to be administered.