

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

Anticipated side effects: _____

I hereby give my permission for _____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication. I further 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 an adverse drug reaction suffered because of administering the drug.

Date: _____

Signature of Parent or Guardian

Note: The 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.