PARENT/GUARDIAN PERMISSION OF ADMINISTRATION OF MEDICATION

Student: ______________________________ School: ___________________

Date of Birth: __________ Grade: __________ Teacher: __________________

Attending Physician: ____________________________

Physician's Address: ____________________________ Phone: ____________

Type of Medication: ____

Purpose of Medication: ____

Prescribed Dosage: _______________________ Frequency: ________________

Time(s) to be Administered: ____

Comments regarding prescription and/or other instructions:

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Possible side effects: ____

I, the undersigned parent or legal guardian of _________________________ hereby request that my child be administered his/her prescribed medication at school. I understand medication is to be brought directly to the school office in a properly labeled container provided by the pharmacist. I understand medication is to be administered in accordance with directions of his/her physician as indicated above. Furthermore, my request and permission for administration of medication constituted my agreement to indemnify, hold harmless, and release the district, its employees and agents from any and all claims and liability arising from the administration of medication requested above.

Parent/Guardian: _______________________ Date: ________________________

Signature: ____________________________ Telephone: ___________________