Parent and Physician Permission
for Administration of Medication by School Personnel

I request and authorize the school nurse/principal/or designated person to administer to;

Name of Student_____ Grade Level_____

Name of Medication_____

Amount to be Given_____

Time(s) to be Given_____

Length of Administration_____ number of school days _____entire school year

****If "**entire school year**" is checked a physician's signature is required below****

Reason for Medication:_____

Significant Side Effect(s)_____

Inhaler to be carried by student _____yes_____no

_____ _____

(Parent/Guardian Signature) (Date) (Physician's Signature) (Date)

I hereby request that the School District, or its authorized representative, administer the drug named above to my child named above, in accordance with the prescribing physician's instructions, and agree to:

1. Submit this request to office personnel
2. Make sure that the medication is brought to school in its original container and/or packaging.
3. Make sure the container in which the drug is dispensed is marked with the drug name, dosage, interval dosage, and date after which no administration should be given.
4. Any medications left at school will be destroyed at the end of the school year
5. Over the counter medications must have dosage(s) labeled for the age of your child.
6. Medications will not be administered past the expiration date.
7. Release the School District and the Board of Education of the School District and all employees, agents, and the representatives of the School District from any liability concerning the giving or non-giving of the drug to the student.