SCHOOL HEALTH SERVICES
Medication Administration
Parental Permission Form

All medicine, prescription and non-prescription (over-the-counter), must be sent in the original container labeled with the student's name and accompanied by written instructions from the physician, certified registered nurse practitioner, physician assistant or dentist.

PRESCRIPTION AND NON-PRESCRIPTION MEDICATION		
Student Name:	Age:	Grade:
Medication:	Dosage:	Time:
Dates to be Administered:	Amount Sent:	
Reason for Medication:		
Side Effects:		
Prescribed by Physician/Dentist Name: Phone: ( )		
List all other medication your child is currently taking:		

I hereby agree that the above medication be administered to my child as ordered by his/her health care provider. I agree with the intent to be legally bound hereby, to hold the Hampton Township School District and any of it's employees or agents harmless from any liability and to so indemnify same for any liability incurred which may result from administration or supervision of the medication to my child by employees or agents of the Hampton Township School District.

_______________________________ / ___________________________
Parent/Guardian Signature Date

Home Phone: ( ) ________ - __________
Work Phone: ( ) ________ - __________

Rev. 5/10