PARENT PERMISSION FOR PRESCRIPTION MEDICATIONS

Date _____ Student's Name _____

Birthdate _____ Address _____ City _____

Franklin Monroe Elementary Grade _____ Teacher _____

I hereby request and grant permission for the above named school to supervise the medication routine below prescribed for the above-named child.

We/I hereby release _____ (designated medication administrator), Franklin Monroe School, the Board of Education, the Principal, any supervisory personnel, their heirs, executors, administrators, or successors, from any and all liability that may arise out of services rendered in dispensing the below named medication.

I further agree to submit a revised statement signed by the physician who prescribes this drug, if any of the information below changes.

_____
Parent's Signature

PRESCRIPTION MEDICATIONS

MEDICATIONS MUST BE IN ORIGINAL MEDICATION OR PRESCRIPTION BOTTLE

Medication (name, dosage, route) _____

_____

Reason for use _____ Storage Conditions _____

Date to Begin _____ Date to Cease _____

Time or intervals dosage of drug is to be administered _____

Special instructions and/or adverse effects _____

Medication (name, dosage, route) _____

_____

Reason for use _____ Storage Conditions _____

Date to Begin _____ Date to Cease _____

Time or intervals dosage of drug is to be administered _____

Special instructions and/or adverse effects _____

Medication (name, dosage, route) _____

_____

Reason for use _____ Storage Conditions _____

Date to Begin _____ Date to Cease _____

Time or intervals dosage of drug is to be administered _____

Special instructions and/or adverse effects _____

_____ _____
Physician's Signature Physician's Phone # (in case of questions or emergency)