Permission to Administer Prescription Medication

Name of Student_____

Name of School _____ Grade _____

Medication _____ Dosage _____

Medication start date _____ Duration _____

Time of day to be given _____

Date _____ Physician's Signature _____

Anticipated Side Effects _____

_____

I consent to the school nurse, or other district healthcare provider, to prescribe, dispense, or administer this medication to my child in any school facility as ordered above. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers this 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 from the medication.

_____ _____

Signature of Parent or Guardian Date

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 student, name of medication, dosage, route of administration, directions or interval for the drug to be given, expiration date of the medication, name of licensed healthcare provider prescribing the medication, and pharmacy contact information.

Written authorization to administer prescription drugs will expire automatically at the end of each school year. A new authorization will be required annually.

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