SUMNER COUNTY SCHOOLS
PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student _____ **Date of Birth** _____

School _____ **Grade** _____ **Teacher** _____

Medication Name _____

Dose/Route/Frequency _____

Time of day medication is to be given _____

Purpose of medication _____

Possible side effects/Contraindications _____

Medication Order End Date _____

_____ _____
Signature of Physician/Provider **Date**

_____
Print Physician/Provider Name

_____ _____
Office Phone **Office Fax**

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby agrees to release the Sumner County School System and its personnel from any legal claim which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for _____ to take the above medication. I understand that it is my responsibility to furnish this medication. I further understand that my signature gives Sumner County School Nurses permission to disclose and receive medical information regarding this student on a need-to-know basis.

_____ _____
Signature of Parent/Guardian **Date**

_____ _____ _____
Home # **Work #** **Cell #**

Nurse Signature **Date**

12/2023