

Shoals Community School Medication Permission Slip

(This form must be completed, signed and accompany medication)

PLEASE USE THIS FORM WHEN SENDING IN A PRESCRIPTION OR AND OVER-THE-COUNTER MEDICATION FOR YOUR CHILD. A DOCTOR'S SIGNATURE ON THIS FORM, OR A DOCTOR'S NOTE **MUST** ACCOMPANY ALL MEDICATIONS. THIS INCLUDES PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATION (INCLUDING TYLENOL, COUGH DROPS, ETC....)

STUDENT MEDICATION PERMISSION SLIP	
School:	Grade:
Student's Name:	
Medical Condition:	
Medication:	
Time:	Amount:
Number of days medication will continue:	
Physician's Name:	
Physician's Phone Number:	
Physician's Signature:	Date:

As Parent/Guardian, I have read and understand that I accept legal responsibility for the safe arrival of my child's medication to his/her school. I authorized the designee of the above named school to administer the medication as prescribed above. I accept full responsibility of the effect that this drug may have on my child and absolve the school personnel of liability regarding it. Note: (A nurse is not always present in the school; therefore a secretary or other designee may be assigned to administer medication.) The school nurse may contact my child's physician if there are any questions regarding this medication. The school nurse may consult school staff about this student and his/her medication.

****Parents must supply ALL medications for their child, including all over-the-counter medications (Tylenol, cough drops, etc...)****

Parent's Printed Name

Parent's/Guardian Signature

Date

Parent's Address

Home Phone: _____

Work Phone: _____