GMSD Medication Acceptance Form

20__ - 20__ School Year

_____ Grade: _____

Medication: _____ Dose: _____

DOB: _____ Initial Quantity: _____ Expiration date: _____

Purpose: _____

Time Administered: _____

This certifies that I, the undersigned parent/ guardian, am aware of the terms of the above authorization and hereby request that they be carried out accordingly.

Parent Signature:_____ Contact Number:_____

Email:_____

***Acknowledgement Statements:**

Permission to give meds at school: I hereby give permission for my child to receive medication from authorized personnel to administer medication that I have checked into the school.

Medication Disposal: I am aware that if my child's medication is not picked up by dismissal on the last day of school, it will be disposed of following our TN School Health Clinic Guidelines.

Parent Name: _____ Date: _____

Parent Signature: _____

Nurse/Medical Records Clerk Signature: _____ Date: _____

Date	Dosage	Amount	Parent Signature	Office Signature	Date Med Received