DISPENSING OF MEDICATION
Permission Slip

NOTE: THIS FORM IS TO BE COMPLETED AND SIGNED BY BOTH THE PHYSICIAN AND PARENT/ GUARDIAN BEFORE ANY MEDICATION WILL BE DISPENSED.

Student's Name _____ Date of Birth _____

School _____ Grade _____

Teacher's Name _____

Physician's Name _____

I hereby give permission for _____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any 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 suffered by my child as a result of administering such drug.

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 medication, the dosage, and times to be administered.

No over the counter oral medication (specifically Tylenol/Ibuprofen) will be provided to the students, it is the responsibility of the parent to provide the medication with the child's name on it.

Parent's Signature _____

Daytime Phone Number _____ Date _____

To be completed by physician if administering prescription medication:

Medication:_____ Dosage _____

Date Started: _____ Anticipated Number of Days to Be Administered: _____

Time of Day Medication Is To Be Given _____

Route of Administration:_____

Reason Prescribed:_____

Physician's Signature _____

Daytime Phone Number _____ Date _____