REUBEN B. MYERS SAS

SCHOOL YEAR 2025-2026

PERMISSION TO ADMINISTER PRESCRIPTION MEDICATION AT SCHOOL

This form must be updated for each medicine yearly

STUDENT'S NAME_____GRADE_____

TEACHER'S NAME_____

MEDICATION NAME_____

DOSAGE_____

TIME OF ADMINISTRATION_____

SPECIAL INSTRUCTIONS_____

_____

MEDICAL REASON FOR MEDICATION_____

_____

MEDICAL REASON OF PHYSICIAN_____

_____

EMERGENCY NUMBER

1. NAME_____PHONE_____
2. NAME_____PHONE_____

ALL MEDICATION MUST BE IN THE ORIGINAL BOTTLE
ADULTS NEED TO BRING MEDS TO THE SCHOOL

I hereby authorize designated school personnel to administer the above prescribed medication according to the directions. I agree, by signing this statement that I will not hold liable Canton School of Arts & Sciences or Canton Public Schools District, the school building personnel, or any other designated staff member for following the direction of above physician's order.

SIGNATURE_____DATE_____

I hereby authorize that, if necessary, the school secretary (or anyone deemed appropriate by the principal in the absence of the secretary).

STAFF SIGNATURE _____DATE_____

BOTH PHYSICIAN & PARENT SIGNATURES ARE REQUIRED