

**Permission for Prescription Medication**  
**(Administered by School Personnel)**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Teacher \_\_\_\_\_ Grade \_\_\_\_\_ Allergies \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dose to be given \_\_\_\_\_

Time to be given \_\_\_\_\_ How often to be given \_\_\_\_\_

Reason for medication \_\_\_\_\_

Start date \_\_\_\_\_ End Date \_\_\_\_\_

**Printed Name of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Health Care Provider (required)** \_\_\_\_\_

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**Parent Permission**

I hereby give my permission for \_\_\_\_\_ to have the school to administer the above prescription medications as ordered.

I understand that it is my responsibility to bring the above medication to school in the original, correctly labeled container from the pharmacy.

I understand that any school employee, who administers the medications in accordance with written instructions provided on this form, shall not be held liable for damages as a result of any adverse medication reaction suffered by the student.

I also give permission for the exchange of information between the school representatives, Healthcare provider or pharmacy in the event a question or concern may arise.

**Printed name of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_

**NOTE:**

1. Each medication is to be brought to school in the original, correctly labeled container from the pharmacy.
2. No medication is to be delivered or picked up from the school by a student. The parent or guardian is responsible for delivering and pick up any medications from the school to due to liability issues.
3. Sharing of prescription medications is not permitted.
4. A signed form is required to administer medication at school. It is the responsibility of the parent or guardian to obtain the Healthcare providers signature.

Approved 9/12/2011