

USD #466

PERMISSION FOR MEDICATION

Name of Student _____

School _____

Grade _____

Teacher _____

Medication _____ **Dosage** _____

Time of day Medication is to be given _____

Date _____

Signature of Physician

I hereby give my 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 student 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 the student as a result of administering such drug.**

Date _____

Signature of Parent of Guardian

Note: This 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.