PERMISSION FOR MEDICATION
CENTRE USD 397
FY 23-24

Name of Student: ____

School: ____ Grade: ______________________

Teacher: ____

Medication: ____ Dosage: _____________________________

Date Medication Started: ___________________________ Termination Date: ____________________________

Time of day medication is to be given: ____

____

Diagnosis: ____

______________________ ____
Date Signature of Physician

I hereby give my permission for ____ to take the above medication at school as ordered. I understand that it is my responsibility to provide this medication. I further understand that any school employee who administers any drug or nonprescription medication pursuant to parental written request 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 medication reaction suffered by the student because of administering such medication.

______________________ ____
Date Signature of Parent or Guardian

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 and given to the front office as soon as it is brought in.

08/05/15