MISSION VALLEY SCHOOLS USD 330
ESKRIDGE, KS

Permission for Prescription Medication

Name of Student:____

School: ________________________________ Grade ____________

Teacher: ____

Medication: ____

Amount to be given: ______________________________________

Time it is to be given at school:__________________________________

Manner (route) in which it is to be given: __________________________

Date medication was started (first dose needs to be given at home) ______________

Anticipated number of days medication will be needed:____________________

Reason for medication: ____

Date: __________________ ______________________________
Signature of Physician

For Parent/Guardian:

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 understand that 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 it is to be administered.

I further understand that any school employee who administers the drug to my child, in accordance with written instructions from the physician or dentist, shall not be liable for damages which might occur from an adverse drug reaction suffered by my child as a result of administering such drug.

Date: __________________ ______________________________
Signature of Parent/Guardian