Administration of Prescribed Medications Permission Form for School Year 2019-2020

I give my permission for _____ to take the **prescribed** medication below as directed by the physician. I further understand that it is my responsibility to furnish the medication and that any school employee who administers any drug to my student in accordance with the written directions from the physician shall not be liable for damages as a result of an adverse drug reaction suffered by the student.

Medication _____ Dosage _____
Date Medication started _____
Diagnosis _____
Time of day medication is to be given _____

Signature (Parent/Guardian)_____ date _____

Signature of Physician:_____