MILFORD PUBLIC SCHOOLS
Milford, NE 68405

MEDICATION PERMISSION

Student Name:________________________________

Date of Birth:______________________

I give my permission for the school nurse or authorized school personnel to

administer ____ as prescribed
(Name of Medication)
by _________________________________.
(Physician's Name)

I understand that should my child have a reaction or have any ill effects from the above medication, the school and/or administering personnel will not be held liable.

Signature of parent:____

Date:___________________________

Directions for medication use (Tell how many to take and how often):
____

____.