MEDICATION PERMIT

TO BE COMPLETED BT PARENT/GUARDIAN

I request that my child___________________________, grade______receive the medication as prescribed by our physician in the form below. The medication is to be furnished by me as required by Board policy. I understand that the district is rendering a service and does not assume any responsibility for this matter. I further understand that the school nurse or designated person will administer the medication.

Signature (Parent/Guardian)____

Phone number______________________________Date____________________

I request that my son/daughter receive the following medication:

Name of student___________________________Diagnosis____________________

Name of medication____

Prescribed dosage and means of administration____________________________

____

Time to be taken during school hours____________________________________

Expected duration of treatment____

Possible side effects and adverse reactions_______________________________

Other recommendations____

Signature_________________________________ Phone__________________

Date______________________