USD 113 PRAIRIE HILLS
PERMISSION FOR MEDICATION FORM

NAME OF STUDENT: _____ GRADE: _____

SCHOOL:_____ TEACHER:_____

MEDICATION:_____ DOSAGE:_____

TIME OF DAY MEDICATION TO BE GIVEN: _____

DATE MEDICATION STARTED: _____

REASON FOR MEDICATION: _____

COMMENTS: _____

PHYSICIAN SIGNATURE: _____

DATE:_____

I hearby give my permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any medication 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 reaction suffered by the student because of administering such medication.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

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, dosage, time to be administered and child's name.