



**Administering Medicines to Students**  
(Permission for Medication)

Name of student: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Time of day medication is to be given: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Anticipated number of days it needs to be given at school: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of physician

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by School District Eight, the undersigned parent or guardian hereby agrees to release School District Number Eight and its personnel from any legal claim which they now have or may hereafter have arising out of the administration of or failure to administer the medication to the student.

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.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or guardian

*Note: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy or physician stating the name of the medication and the dosage.*