PERMISSION FOR ADMINISTRATION OF MEDICATION
UNIFIED SCHOOL DISTRICT 378

_____
(STUDENT'S NAME)

_____ _____ _____
(SCHOOL) (TEACHER) (DATE)

_____
(NAME OF MEDICATION)

_____
(REASON FOR MEDICATION)

_____
(DOSAGE)

_____ _____
(DATE STARTED) (TIME OF DAY TO BE ADMINISTERED)

_____
(PERIOD OF TIME TO BE DISPENSED-----EXAMPLE: 10 DAYS, 3 WEEKS, INDEFINITELY)

_____ _____
(DATE) (PHYSICIAN'S SIGNATURE)

- -

I hereby give my permission for _____ _____
(CHILD'S NAME)
to take the above prescription at school as ordered. I understand it is my responsibility to furnish this medication. I further understand any school employee who administers any drug to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by my child because of administering such drug.

_____ _____
(DATE) (PARENT/GUARDIAN SIGNATURE)

NOTE: All medications are to be brought to school in the original container.

COMMENTS: _____

_____

_____

_____