PARENTAL PERMISSION

I request that a member of the school staff give medication to my child _____, according to a doctor's orders.

I understand that either the principal, teacher, the school secretary, the school nurse, the guidance counselor, the assistant principal, the teacher's aide, school educational curriculum coordinator, clerical aide or attendance clerk may give the medication.

I have attached a statement from my child's physician naming the medication(s) to be given, the dosage and the time(s) the medication should be given.

I will not hold the school, school district or school personnel liable for any adverse drug reaction when the medicine is administered according to prescribed methods.

I give permission for the physician and school to share information on the student.

_____

Signature of parent/legal guardian

PHYSICIAN'S PERMISSION

My patient, _____, date of birth_____ needs to take the following medication(s).

Medication	Dosage	Time(s) to be given	Route of Administration	Termination date

Possible side effects: _____

May self-medicate with emergency medication: ___yes ___no

It is necessary that he/she be given this medicine while attending school.

_____

Type or print physician's name

_____ _____

Physician's signature Date

_____ _____

Telephone number Fax number