

**Santa Fe Trail
USD 434**

Permission for Medication

Name of Student _____

School _____ Grade _____

Teacher _____ Physician _____

Medication _____ Dosage _____

Diagnosis _____ Date Started _____

Time of day medication is to be given _____

I hereby 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 drug or nonprescription medication pursuant to parental written request 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 medication reaction suffered by the student because of administering such medication.

Date

Signature of Parent or Guardian

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, the dosage and times to be administered.

Date

Signature of Health Care Provider
(Required for Prescription Medications)

Approved: 8/05