USD 217 Rolla Schools

Permission for Prescribed Medication

Name of Student_____

School_____ **Grade**_____

Teacher_____

Name of Physician _____

Medication_____ **Dosage**_____

Date medication started _____ **Duration** _____

Time of day medication is to be given _____

_____
Signature of Physician

Date_____

Anticipated side effects_____

_____

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. I further understand that 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 because of administering the drug.**

_____
Signature of Parent of Guardian

Date_____

NOTE: The medication must 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.