

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.