

**MEDICATION DISPENSATION FORM
PARENTAL PERMISSION**

I request the enclosed medication in the original container to be administered to my child as prescribed and shall release school personnel from all liability. I give the school nurse permission to contact the physician and/or pharmacist with any question concerning the medication.

Name of Child _____

Name of Medication _____

Signature of Parent/Guardian

Date

- In case of Asthma or potentially life-threatening illness, will the student be giving himself/herself this medication? YES or NO. If yes, please sign below.

We, the parent/guardians of the pupil, acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that we shall indemnify and hold harmless the district and its employees or agents against any claims arising out of self-administration of medication by the pupil. The permission is effective for the school year, which it is granted.

Signature of Parent/Guardian

Date

DOCTOR'S AUTHORIZATION

Name of Patient _____

Name and strength of Medication _____

Time and Route of Administration in school _____

Reason for Medication _____ Dosage _____

Effective Dates: From _____ To _____

Most common side effects: _____

It is my understanding the school nurse in charge with the administration of medication may rely upon my direction as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

Doctor's Name (Please Print)

Doctor's Address

Medication Allergies

City, State and Zip Code

Date

Doctor's Telephone

- I certify that the pupil has asthma or another life threatening illness and is capable of and has been instructed in the proper method of self-administration of medication.
- In case of ASTHMA or potentially life threatening illness, will the student be giving himself/herself the medication? YES or NO. If yes please sign below.

Doctor's Signature