Unified School District Number 292
Grainfield, KS 67737

Permission for Medication

Name of Student_____

School_____ Grade_____

Medication_____ Dosage_____

Date Medication Started_____

Time of Day Medication is to be Given_____

Date_____ _____
Signature of Physician

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 student 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 by the student as a result of administering such drug.

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 THIS MEDICATION, THE DOSAGE, AND TIMES TO BE ADMINISTERED.