

PERMISSION FOR MEDICATION
(Prescription and Non-Prescription)

Name of Student _____

School _____ Date _____

Teacher _____

Prescription Number _____ Licensed Prescriber's Name _____

Medication Name _____ Dosage _____

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____

Directions/time for administration of Medication _____

Purpose of Medication _____

Possible Side Effects _____

Anticipated number of days it needs to be given at school _____

Date _____

Signature of Physician (if requested by the principal)

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by the Manchester City Schools, the undersigned parent or guardian hereby agrees to release the Manchester City Schools and its personnel from any legal claim which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication.

My child is competent to self-administer the above medication with assistance: YES ___ No ___

If no please explain: _____

I hereby give my permission for _____ to take the above
name of student
medication as ordered. I understand that it is my responsibility to furnish this medication.

Date _____

Signature of parent or guardian

Home Phone _____ Work Phone _____ Emergency Phone _____

ISSUED 08/15/97