Prescription Medication Release Form

Name of Student_____

School_____ Grade _____

Teacher_____

Medication_____ Dosage_____

Date Medication started_____

Time of day medication is to be given_____

_____ Date_____
Signature of Physician

_____

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 because of administering such drug.

_____ Date_____
Signature of Parent/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 the medication, the dose and the time to be administered.