Mulvane Public Schools

PARENTAL PERMISSION FOR ADMINISTERING MEDICATION AT SCHOOL

I hereby give my permission for the school nurse or other designated school employee to see that my child_____ receives the medication prescribed by Dr._____ for the period from_____ to _____.

This medication is to be furnished by me and the following information shall be provided with the medicine:

Name of medicine_____

Amount to be given_____

Time of day to take_____

Expected number of days of treatment_____

I hereby agree that any designated school employee who administers any medication to my child in accordance with written instructions from my physician or from myself shall not be held liable for any damages as a result of any adverse reaction suffered by my child as a result of the administering of such medication.

_____	_____	_____
Date	Signature of Parent/Guardian	Physician's Signature

NOTE: The medication is to be brought to school in the original container with an appropriate label, which shall state the name of the medication, the dosage, and the times to be administered.