Scott County School District 2

Committed to Helping Every Child Succeed

Permission to Give Prescription Medications

Student Name:________________________________ **Date of Birth:** ________

School:_______________________________________ **Grade:** ______

This is to inform you that the above named student, enrolled in your school, is currently under my medical care. As a part of that care, this student must receive the following medication as directed below.

Indicated Medical Diagnosis: ____
Medication: ____
Dose: ___________________ **Interval** ______________________ **Route** ______
Length of Therapy: ____
Additional Information: ____

I request and authorize you to administer this medication in accordance with the above instructions.

_______________________________ _______________________________
Physician Signature Address

_______________________________ _______________________________
Telephone Date

We, as the parent/guardian of the above student, give permission to administer the medication described above in accordance with the instructions provided. We agree to notify you immediately of any change in circumstances concerning administration of this medication.

Parent Signature: ____________________________
Address: ___________________________________
Telephone: _________________________________
Date: ______________________________________