SHENANDOAH COMMUNITY SCHOOL PARENT PERMIT FOR MEDICATION ADMINISTRATION

I, the undersigned parent or guardian of (student's name) _____ hereby request the Shenandoah Community School District, or its authorized representative, to administer the following prescription medication to my child:

Medication: _____
Dosage: _____
Time/Times to be Administered: _____

The medication has been prescribed by Dr. _____ (for prescription drugs only). Please list the reason the medication is to be given and any special directions.

_____
_____
_____

I understand that I am personally responsible to ensure that the medication is received by the school in the container in which it was dispensed by the physician or pharmacist or is in the manufacturer's container. I also ensure that the container in which the medication is dispensed is marked with the correct medication name, dosage, directions for time of administration and the correct student's name.

_____
Parent/Guardian's Signature Date