

Pratt Unified School District No 382

Request for Medication to be Administered During School Attendance

Name of Student _____

School _____ Grade _____

Diagnosis _____

Medication _____ Dosage _____

Time of Day Medication is to be given _____

Date _____

Signature of Physician

I hereby give my permission for my student _____ 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 or failure to administer such drug.

Date

Signature of Parent or Guardian