Fayette County Public Schools

Family – Optimism – Courage – Unity – Service

Dr. Marlon D. King
Superintendent

Permission to Administer Medication

School _____

Student's name: _____ DOB: _____

Parent's name: _____

Address: _____

Phone numbers: _____

Emergency contact person and number: _____

****

Physician: _____

Phone number: _____ Fax: _____

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Name of medication: _____ Dosage: _____

Time of medication: _____
(Please write time of dosage at school only)

Duration of administration: ___ Days _____ Weeks _____ All year

Reason for medication: _____

Possible side effects and treatment: _____

I request the designated employee of the Fayette County School System to administer medication to my child. I agree to hold harmless the school district and Board of Education from any all liability relative to the administration of such medication.

I give my permission to the school nurse or designee and my child's physician to exchange medical information relative to the medication mentioned above.

IMAG21NE

Signature: _____ Date: _____

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