MEDICATIONS DURING SCHOOL HOURS FORM

MEDICATION DURING SCHOOL HOURS

DATE________________________

I request and give permission for __________________________to receive the following medication during school hours:

Name of Medicine: ____

Dosage: ____

Time schedule: ____

Length of Time: ____________________to ____________________

Reason for Administration: ____

Any curtailment of activities? ____

Any change in type or dosage of medication must be reported, in writing, to the school immediately.

I hereby release the Lakeland School District and its employees from any liability or responsibility for any damages that may result from the administration of the medication in accordance with this request.

____________________________________ _________________________

Parent/Guardian Signature Date