Shawnee Local Schools
Medication Permission Form

_____ _____
Student Address
_____
_____

_____ _____
Teacher School

_____ _____
Name of Drug Dosage to be Administered

_____ _____
Time/Interval for Administering Purpose

_____ _____
Medication Beginning Date Medication Ending Date

_____
Any severe, adverse reactions which should be reported to physician.

_____

_____

_____
Special Instructions

_____ _____
Physician Name Physician Phone number

_____ _____
Physician Signature Date

All medication must be transported to the school by the parent/guardian. The parent should pick up any unused medication.

On behalf of myself, my child, and his/her other custodial parent or guardian, if any, and on behalf of our heirs and assigns, I hereby request the Shawnee Schools to administer this medication to my child. I hold harmless the Shawnee School and its officers, agents and employees in the administration to my child or in the failure to administer this medication to my child.

_____ _____
Parent/Guardian Signature Date