SUMNER COUNTY SCHOOLS
PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student _____

School _____ **Grade** _____ **Date of Birth** _____

Teacher _____

Medication _____ **Dosage** _____

Purpose of medication _____

Time of day medication is to be given _____

Possible side effects _____

Anticipated number of days to be given at school _____

_____ _____
Signature of Physician/Provider **Date**

_____ _____
Print Physician/Provider Name **Office Number**

_____
Office Address

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby agrees to release the Sumner County School System and its personnel from any legal claim which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for _____ **to take the above medication. I understand that it is my responsibility to furnish this medication. I further understand that my signature gives Sumner County School Nurses permission to disclose and receive medical information regarding this student on a need-to-know basis.**

_____ _____
Date **Signature of Parent/Guardian**

_____ _____ _____
Home # **Work #** **Cell #**

Emergency Medication Administration

Diastat_____ **Epi Pen**_____ **Glucagon**_____

Date/Time given _____ **Signature** _____

Date/Time given _____ **Signature** _____