Sumner County Schools
PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student: _____

School: Portland East Middle 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:_____

_____ _____
Printed Name of Physician **Signature of Physician**

_____ _____
Date **Physician's Phone Number**

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 and its personnel from any legal claim which they now have or may thereafter having arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for _____ **to take**
(Student Name)
the above medication. I understand that it is my responsibility to furnish this medication.

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

_____
Home # Work# Cell#

Parent/Guardian's signature gives Sumner County School System permission to disclose and receive medical information regarding this student.