UNION COUNTY
SCHOOL DISTRICT

Building a More Perfect UNION

PRESCRIPTION MEDICATION PERMISSION REQUEST FORM

Union County School District
School Medication Authorization

School Year:_____

Student_____Date of Birth_____Grade____School_____

Teacher_____Parent/Guardian_____Phone_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Medication_____Dosage_____Route_____Time(s) to give_____

Reason for Medication_____Start Date_____Stop Date_____

Side effects/precautions_____

Provider signature_____

Print Name_____Phone_____Date_____

TO BE COMPLETED BY PARENT/GUARDIAN

My signature in the space below assures that:

1. I hereby give my permission for my child to receive the stated medication at school;
2. I assume full responsibility and will inform school staff of any medication changes or health status;
3. I hereby release UCSD, their agents, and employees from any and all liability that may occur as a result of medication administration;
4. I will provide a new medication form each school year and each time the dose/medication changes;

Signature of parent or guardian_____Phone_____Date_____

TO BE COMPLETED BY THE SCHOOL NURSE

Signature of school nurse_____