



# UNION COUNTY SCHOOL DISTRICT

*Building a More Perfect UNION*

## MEDICATION PERMISSION REQUEST FORM

The Union County School District requires all students who must have prescription medication during school hours to do the following:

- (1) Present this completed form to the school office.
- (2) Bring the medication in the regular prescription bottle labeled by a pharmacist. It is recommended that at least a one- week supply be available.

Name of Child: \_\_\_\_\_

Name of Medication and Dosage: \_\_\_\_\_

Time Medication to be Administered: \_\_\_\_\_ AM / PM

Begin Medication (Date) \_\_\_\_\_ Stop Medication (Date) \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_

Does medication need refrigeration: Yes \_\_\_\_\_ No \_\_\_\_\_

I give permission for my child or ward to receive the above noted medication as directed on the prescription bottle. I understand that school personnel administering the medicine will not have medical or nursing training. I, forever release, discharge, and covenant to hold harmless the Union County School District, its personnel, and its school board from any and all claims, demands, damages, expenses, loss of services, and causes of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss, or damages of any kind resulting from the administration of medicine. I also authorize the school nurse to talk to the prescriber or pharmacist should a question arise about the medicine.

Parent's Name: \_\_\_\_\_

(please print)

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Prescriber: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Witness' Name: \_\_\_\_\_

(please print)

Witness' Signature: \_\_\_\_\_ Date: \_\_\_\_\_