PARENT/GUARDIAN INSTRUCTION/CONSENT FOR MEDICATION ADMINISTRATION

(Please print)

Full name of child to be medicated: _____

Grade: _____ Teacher: _____

*Name of medication: _____ Dosage: _____

Hour(s) medication to be given at school: _____ Number of days: _____

Physician prescribing medication: _____

Physician's phone number: _____

Reason for medication: _____

I hereby give permission for school personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the Seymour Community School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

_____ _____

Signature of Parent/Legal Guardian Phone Number

_____ _____

Address Date

NOTE

- Before prescribed medication(s)* will be administered by the school or an agent thereof, a **PHYSICIAN INSTRUCTION/CONSENT FOR MEDICATION ADMINISTRATION** form must also be completed and returned to the school.
- This form must also be completed for the administration of non-prescription (over-the-counter) medications.
- All prescription and non-prescription (over-the-counter) medications must be in the original container.

*Includes:

prescribed medications, non-FDA approved medications, and over-the-counter medications that exceed recommended therapeutic dose

SOURCE: Seymour Community School District
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- Black Creek Elementary/Middle School- 920-984-9303
- Rock Ledge Primary Center- 920-833-5144
- Rock Ledge Intermediate School- 920-833-9684
- Seymour Middle School- 920-833-9376
- Seymour High School (Health Office)- 920-833-5146