LEGACY ACADEMY

PERMISSION FOR MEDICATION

Full Name of Student: ____ Grade: _________________

Medication: ____ Dosage: ________________

Purpose of Medication: ____

____

Time of day medication is to be given: ____

Possible side effects: ____

Anticipated number of days it needs to be given at school: _________________________________

Permission for student to carry medication: ____

Medication must come in its original container, labeled with the student's name and dosage by physician.

____________________ ____

Date Signature of Physician

It is understood that they medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Legacy Academy, the undersigned parent or guardian hereby agrees to release Legacy Academy and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give my permission for ___________________________________ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

____________________ ____

Date Signature of Parent or Guardian

The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy, or physician, state the name of the medication and the dosage.

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