MADISON COUNTY SCHOOLS

MEDICATION PERMISSION REQUEST FORM

School Year

Student's Name:		Date of Birth:
School:	Grade:	Teacher:

The policy of Madison County Schools states that any student who requires a prescription or non-prescription (OTC) during school hours MUST complete the following: (A & B)

A. **Present** this consent form to the office of the principal or the school nurse. Forms are available in each school office and on-line. **Incomplete forms will not be accepted.**

B. Parent/guardian must bring the medication to the school. **No medication will be accepted by the student.**

- The **prescription** medication must be in a container properly labeled by the pharmacist.
- The **non-prescription (OTC)** medication must be in the original sealed container.

Each school will have designated personnel who will be assisting and/or dispensing the medication to your child.

Medication REQUESTED to be taken during school hours: _____

To be completed by Physician

Time to be delivered:	
Dose to be delivered:	
Route of delivery:	
Length to be taken:	

PHONE NUMBER OF PHYSICIAN OFFICE:	

(PRINTED NAME OF PHYSICIAN)	(SIGNATURE OF PHYSICIAN / DATE)

To be completed by Parent/Guardian

I, _____ give permission for _____,
(parent/guardian) (Student)

to receive the above referenced medication as written by the physician. * I will NOT hold Madison County Schools, its agents, and employees liable for any damage, loss or injury arising from the administration of medicines to my child.

EMERGENCY CONTACT PHONE NUMBERS:	
	(Parent Signature / Date)

*****CHANGES TO MEDICATION MUST BE PRESENTED IN WRITING.*****