Sheffield-Sheffield Lake City Schools
Permission Form for:
Medication to be Administered by School Personnel

Student Name	School	Class
Address		Date of Birth

To be Completed by Physician

Name of Medication	Reason for Medication
Form of Medication/Treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other:	
Instructions	
Dose:	Time Given:
Start Date:	Stop Date:
Side Effects:	
Restrictions:ch	
Special Storage Instructions:	
Physician's Signature	Date
Physicians Name	Phone
Address	

To be Completed by Parents/ Guardians

I give my permission for my child _____ to receive medication at school according to school district policy and as instructed by the physician and agree to:

- Assume responsibility for safe delivery of the medication to the school either by me or my child
- Have a new form completed by the physician if medication or dosage is changed
- Notify the school if we change physicians
- Further, I hereby release from liability and in addition agree to indemnify all school employees and the Board of Education for damages or injury resulting from the use, misuse, non-use of such medication except if such Board of its employees are grossly negligent or engaged in wanton or reckless misconduct.

Parent Signature	Date

This form will expire at the end of the current school year