PLYMOUTH COMMUNITY SCHOOL CORPORATION

Student Medication/Treatment Permit

To the School Nurse:

School: _____ Date: _____

My patient: _____ in grade _____ is taking the following

medication and/or treatment _____ for this

condition _____.

It is to be taken during the school day as follows:

_____ _____

Physician's Name Physician's signature

_____ _____

Address Telephone Number

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To be completed by parent and/or guardian:

A. I give my permission for the above medication to be give at school as prescribed by the physician.

B. I give my permission for my son/daughter to carry their own inhaler or beesting kit. We have discussed the importance of not sharing this medication with other students.

C. I will assume responsibility for safe delivery and pickup of the medication to and from school.

D. I will notify the school immediately if there is any change in the use of the medication or prescribed treatment.

E. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent Date

_____ _____

Address Home Telephone

_____ _____

Work Telephone Email/Fax