Medication Administration
Parental Permission Form

All <u>medicine must be in original container</u> labeled with:

1. **Name of child**
2. **Amount of medication to be taken**
3. **Time medication is to be taken**

PRESCRIPTION AND NON-PRESCRIPTION MEDICATION		
Student Name:	Age:	Grade:
Medication:	Dosage:	Time:
Dates to be Administered:	Amount Sent:	
Reason for Medication:		
Side Effects:		
Prescribed by Physician/Dentist Name: Phone: ( )		
List all other medication your child is currently taking:		

I hereby agree that the above medication be administered to my child as stated herein and agree with the intent to be legally bound hereby, to hold the Hampton Township School District and any of it's employees or agents harmless from any liability and to so indemnify same for any liability incurred which may result from administration or supervision of the medication to my child by employees or agents of the Hampton Township School District.

_____ / _____

Parent/Guardian Signature Date

Home Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____