Egremont School

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School Medication Permission Agreement

Student's Name	Date of Birth	Emergency Phone Number
Teacher	**Grade**	**Date**

PARENT/GUARDIAN: We at Egremont School realize it may be important for a student's well being that medicine be taken at school. It is also important that such medicines be approved and that administration of medicine follows school policies and guidelines based upon a physician's written authorization. This form is required before the school administers any medications. A separate form is required for **each medication** the student may be taking. Please include authorization and instructions from the student's physician or an authorized and qualified medical advisor.

MEDICATION INFORMATION

Name of Medication _____

Condition Treated by this Medication _____

Dosage _____ Time(s) of Use _____

Duration Period Student Will Be Taking This Medication _____

Is Medication Necessary For Child to Remain in School? _____Yes _____ No

Will Child Experience any Side Effects _____ Yes _____ No Possible Side Effects _____

Has Student Been Informed of Parent and Physician Instructions for Use and Storage of This Medicine?____ Yes ____ No

Special Storage Instruction Request _____

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER

Parents are aware of the school's policies and procedures related to medication by school personnel? ____ Yes ____ No

Describe all administration conditions and procedures that those giving the medication should be aware of:

_____

_____

AUTHORIZATION SIGNATURES

PARENT/GUARDIAN: Your signature indicates the accuracy of the above information and your acknowledgement of school policies and guidelines for the administration of medication. **(No Cough Drops Will Be Given to Any Student)**

Please Print Parent/Guardian Name(s) _____

I, (we)_____ hereby grant permission for Egremont School and/or its personnel to administer the above medication according to doctor's written orders and school policy.

Signature _____ Date _____