PERMISSION FORM FOR ADMINISTRATION OF MEDICATION

I, _____, hereby grant permission for the principal or his/her designee to administer to my child, _____, the following medication(s):

1. _____ Dosage _____Time(s) _____
Reason_____
Number of days to be given _____
2._____Dosage _____Time(s) _____
Reason_____
Number of days to be given _____
3. _____Dosage _____Time(s) _____
Reason _____
Number of days to be given _____
4. _____Dosage _____ Time(s) _____
Reason _____
Number of days to be given _____

I understand that the Jackson Public School District by law shall incur no liability on any claims relating to the administration of medications to my child. I further agree to indemnify and hold harmless the Jackson Public School District and its employees against any claims relating to the administration of medication to my child.

Attached to this permission form is a written statement from my F K L O G ¶ V health care practitioner, _____, the name and purpose of the medication and their prescribed dosage, the time the medication is to be

I understand that this permission form is only effective for the school year in which it is granted and that I must renew it each school year hereafter.

SIGNED

_____
3 $ 5 (1 7 ¶ 6 1 $ 0 (

_____
ADDRESS

_____
PHONE NUMBER

_____
DATE

SOURCE: MISSISSIPPI SCHOOL BOARDS ASSOCIATION; JACKSON PUBLIC SCHOOL DISTRICT
DATE: May 15, 2006
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