Gibbon Public School

Permission for Medication Administration

Student: _____ Date of Birth: _____

Grade: _____ Age: _____ Allergies: _____

_____

(Medication name and dosage needing administered)

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(Frequency or time during the day medication needs administered)

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**MEDICATION MUST BE IN ORGINAL BOTTLE**

I understand that monitoring the effects of the above listed medication is not the responsibility of the school staff, but that of the parent and/or student's physician. I also understand that a school staff member other than the school nurse may have to administer this medication to my child under the direction and monitoring of the school nurse at times.

_____ Date: _____

(Signature of parent/guardian)

**A new medication administration form must be completed each time a new medication is ordered/advised/or dosage changed. This must be done prior to the schools legal ability to administer that medication to your child **