

## SUMNER COUNTY SCHOOLS PERMISSION FOR ADMINISTRATION OF <u>PRESCRIPTION</u> MEDICATION

Name of Student		Date of Birth
School	_ Grade	Teacher
Medication Name		
Dose/Route/Frequency		
Time of day medication is to be given		
Purpose of medication		
Possible side effects/Contraindications		
Medication Order End Date		
Signature of Physician/Provider		Date
Print Physician/Provider Name		
Office Phone		

Date

**Nurse Signature**