CLEVELAND CITY SCHOOLS
PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student____

School ________________________________Grade__________________

Teacher____

Medication _________________________Dosage_____________________

Purpose of Medication____

Time of day **medication** is to be given____________________________

Possible side effects____

Anticipated number of days it needs to be given at school_______________

______________________ ______________________________

Date Signature of Physician

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by Cleveland City School System, the undersigned parent or guardian hereby agrees to release the Cleveland City School System and its personnel from any legal claims which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for to take the above prescription as ordered. I understand that it is my responsibility to furnish this medication and agree (by my **signature** below) that my child is competent to **self-administer** his/her medication.

______________________ ______________________________

Date Signature of **parent/guardian**