



SUMNER COUNTY SCHOOLS
PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

Name of Student _____ Date of Birth _____

School _____ Grade _____ Teacher _____

Medication Name _____ ****Will ONLY be given per label directions****

Purpose of medication _____

Time of day medication is to be given _____

Possible side effects _____

Medication Order End Date _____

Name of Physician _____ Physician Contact _____

Alternative Medicines: "herbs, herbal supplements, homeopathic medicines, vitamins, traditional or cultural treatments, salves, nutritional supplements, and other products that are not generally considered part of conventional medicine will not be administered at school. The actions and potential side effects of these products are not readily available to health care providers and cannot be safely administered by school staff."

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 request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby agrees to release the Sumner County School System and its personnel from any legal claim 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 medication. I understand that it is my responsibility to furnish this medication. I further understand that my signature gives Sumner County School Nurses permission to disclose and receive medical information regarding this student on a need-to-know basis.

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Signature of Parent/Guardian

Date

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Phone 1

Phone 2

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Nurse Signature

Date