



**SUMNER COUNTY SCHOOLS**  
**PERMISSION FOR ADMINISTRATION OF PRESCRIPTION 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

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**Nurse Signature**

**Date**