Monument Academy

Permission for Prescription and Non-Prescription Medications

Name of Student:_____ Date of Birth: _____

Grade_____ Teacher _____

Medication:_____ Dosage _____

Purpose of medication_____

Time of day medication is to be given _____

Possible side effects _____

_____	_____	_____
Date	Signature of Doctor/ Licensed Prescriber	Phone
_____		_____
Print: Doctor/ Licensed Prescribers Name		Fax

Parent or Guardian please indicate your choice by checking the appropriate box and sign and date below:

1. I give my permission for my child's health care provider to complete this form and return to

my child's school by fax or mail.....Yes ☐ No ☐

2. It is understood that 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 staff member of Monument Academy, the undersigned parent or guardian hereby agrees to release Monument Academy and its staff from any legal claim which they now have or may hereafter have arising out of the administration of or failure to administer the medication to the student, or possible side effects or other medical consequences of the medication. I hereby give my permission for my student to take the above medication at school as ordered.

_____ _____

Date Signature of Parent or Guardian