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

Nurse Signature **Date**

12/2023