New Kent County Public Schools
Permission Form for the Administration of Medication at School

Part A – Physician’s Note

I certify that in my opinion it is medically necessary that the medication prescribed below be administered to ____________________________, during school hours and that school personnel may administer this medication.

Medication: ____________________________________________________________

Dosage and Time: _______________________________________________________

Duration: ____________________________________________________________

Condition prescribed for: ____________________________________________

Physician’s signature: _______________________________________________

Date: _________________________________

Part B – Parent’s Note

I, ________________________________________________________________, the parent or guardian of ________________________________________________________, request that the School Nurse or principal designee administer the medication prescribed above to my child during school hours. I understand that the person (principal’s designee) may be a non-medical person giving medications, and agree that I shall not hold such persons or the School Board of New Kent liable in any way for any harm or injury resulting from administration of such medication. I also agree to furnish said medication in the bottle supplied by the drug store with the label intact. I also give consent for medication verification, when necessary with the child’s doctor or pharmacist.

Parent/guardian signature: _______________________________________________

Date: _________________________________