Canton School District
Medication Permission Form

Lawrence Elementary
phone (605)764-2579
fax (605)764-5003

Canton High/Middle School
phone (605)764-2706
fax (605)764-2700

Name of Student________________________________Date of Birth_________

We encourage that you arrange to give medication outside of school hours whenever possible.

PARENT'S STATEMENT (CHECK ONE OPTION)

Option 1 ( ) I request and authorize personnel of the Canton School District to supervise the administration of the medication prescribed on the form to my child. I understand the medication must be provided in a labeled bottle from the pharmacy. If it is not a prescription medication, it must be in its original bottle, labeled with my child's name. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication.

Option 2 ( ) I authorize my child to take his/her own medication while at school and relieve the school district and personnel of all responsibility in this matter.

Parent's signature______________________________ Date _____________

<u>PHYSICIAN'S STATEMENT - REQUIRED IF SCHOOL PERSONNEL ARE TO ADMINISTER THE MEDICATION AT SCHOOL:</u>

1. Name of medication ____
2. Dosage to be given at school __________________________________
3. Time given at school ____
4. Precautions and reactions to observe and report ___________________

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5. Physician's signature ____