MEDICATION PERMISSION

Milford Public Schools

Student Name: _____

Date of Birth: _____

I give my permission for the school nurse or authorized school personnel to administer _____
(Name of Medication)

as prescribed by _____.
(Physician's Name)

Directions for medication use (how many to take and how often):

_____

_____

I understand that should my child have a reaction or have any ill effects from the above medication, the school and/or administering personnel will not be held liable.

Signature of Parent/Guardian:_____

Date:_____