PERMISSION FORM FOR ADMINISTRATION OF MEDICATION

l,	, hereby gra	nt permission for the princip	pal
or his/her designee to a	dminister to my child	,, t	he
following medication(s):			
1	Dosage	Time(s)	
Reason			
Number of days to be given			
2	Dosage	Time(s)	
Reason			
Number of days to be given		<u> </u>	
3	Dosage	Time(s)	
Reason			
Number of days to be given			
4	Dosage	Time(s)	
Reason			
Number of days to be given			
I understand that the	Jackson Public School	ol District by law shall incur	no
liability on any claims relatir	ng to the administration	of medications to my child.	. 1
further agree to indemnify a	and hold harmless the	Jackson Public School Dist	rict
and its employees against a	any claims relating to th	e administration of medicati	on
to my child.			
Attached to this perm	mission form is a writte	en statement from my FI	KLOG¶V
health care practitioner,		, the name and purpose	of
the medication and their p	rescribed dosage, the	time the medication is to	be

I understand that this permission form is only effective for the school year in which it is granted and that I must renew it each school year hereafter.

SIGNED
3\$5(17¶6 1\$0(
ADDRESS
PHONE NUMBER
DATE

SOURCE: MISSISSIPPI SCHOOL BOARDS ASSOCIATION; JACKSON PUBLIC

SCHOOL DISTRICT

DATE: May 15, 2006 REVIEWED: December 6, 2016

August 2017