PARENT REQUEST/PERMISSION
to dispense Medications during School Hours

Please dispense the following medication(s) to my child according to the directions given below.

- Student's Name: _____
- Name of medication: _____
- Purpose of medication: _____
- Prescribed dosage: _____
- Date(s) to be administered: _____
- Time(s) to be administered: _____
- Possible side effects: _____

I release the Southern Reynolds County R-II School District and its personnel from any responsibility arising from the dispensing of this medication in accordance with stated directions.

_____ _____

Parent or Guardian Signature Date

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Parent or Guardian Signature Date