MEDICAL ADMINISTRATION
(Must be renewed each school year)

Date_____

Child's Name_____

Parent / Guardian_____

Administered by_____

Medication _____

Dosage_____

Time (s) to be given _____

Storage of Medication _____

Reason for Medication_____

I request and give my permission for a representative of Aberdeen School District to administer the above medication to my child. The Aberdeen School District, its representatives and School District # 58 are released from any liability in case of over medication, under medication, lack or giving medication or an adverse reaction occurring as a result of the medication.

Additional comments

_____
_____
_____
_____
_____

_____
PARENT / GUARDIAN'S SIGNATURE