

**STUDENT MEDICATION PERMISSION SLIP
GOOD SHEPHERD SCHOOL**

STUDENT'S NAME _____ GRADE _____

NAME OF MEDICATION _____

TIME AND AMOUNT TO BE GIVEN _____

I understand that my signature relieves the school personnel from any and all liability related to the administration of the prescribed medication.
As parent/guardian, I accept the legal responsibility for the safe arrival of my child's medication to school.

Parent/Guardian Signature

Date

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