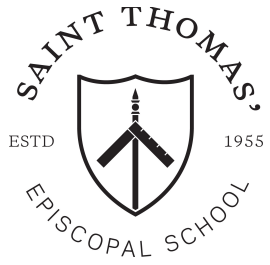

Consent for Administration of Prescription Medication

Student: _____ Grade: _____

Date of Birth: _____

It is necessary that the following medication be administered during school as specified below in order to maintain this child's physical health and support school performance.

Name of Medication: _____ Dosage: _____

Time: _____ Frequency of Use: _____

Condition for which medication is prescribed:

_____

I hereby grant permission for the school nurse or other school personnel to administer to above medication to my child.

_____ _____

Signature of Parent/Guardian Date

Important Information for Parent/Guardians:

Prescription medication must be prescribed by a licensed physician and appropriately labeled in the original container by the pharmacy or physician.