

PERMISSION FOR MEDICATION

Name of Student _____

Name of Medication _____

Dosage _____

Time/Times to be Administered _____

Termination of medication _____

Purpose of Medication _____

Special orders for medication _____

Physician Signature _____ Date _____

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Parent Permission

I request that school staff members administer medication to my child during school hours in accordance with the written instructions from my physician.

Parent/Guardian Signature _____

Date _____

NOTE: The prescription medication is to be brought to school in the original container labeled by the pharmacy, or physician, stating the name of the student, medication, time, and the dosage.