PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Name of Student: _____

Date of Birth: _____ Age: _____Grade: _____ School: _____

Name of Medication: _____ Dosage: _____

_____ Dosage: _____

Time Medication to be given: _____

Reason Medication is prescribed: _____

Possible Side Effects: _____

_____

Doctor's Name: _____

Doctor's Signature: _____ Date: _____

I herby give Permission for school personnel to administer the above medication.

Parent's Signature: _____ Date: _____

IMPORTANT: Parents: Please send medications in the bottles they came in with the child's name on them. Never send medications to school wrapped in a tissue or carried in an envelope, etc. The above information is required before any medication will be administered to a child.