

MEDICATION PERMISSION FORM

STUDENT NAME: _____

MEDICATION NAME: _____

DOSAGE (amount to be given): _____

TIME TO BE GIVEN: _____

BEGINNING DATE: _____ ENDING DATE: _____

- I give consent for my child to be given the above named medication while at school. If prescribed by a physician, I understand that the doctor's prescription must be attached to the original bottle which is to be kept at school.

PARENT SIGNATURE: _____ DATE: _____