

Medication Permission and Administration Form

Child's Name _____

Instructions provided by your doctor are needed in order for your child to take medication at school.

To be completed by parent/guardian:

I hereby authorize any person or persons designated by the principal to assist my child to take the following medications at school:

<u>MEDICATION</u>	<u>DOSE</u>	<u>(START DATE./STOP DATE)</u>	<u>TIME</u>	<u>DIRECTIONS</u>

Diagnosis or reason for medication _____

Date _____ Parent/Guardian Signature _____

Date _____ Physician's Signature _____

I understand that my student will be self administering medications in accordance with the physician's instructions above. I accept ultimate responsibility for monitoring the affects of such medications.

Date _____ Parent/Guardian Signature _____

Phone: _____