

2010-2011  
**Medication Permission and Administration Form**

Child's Name \_\_\_\_\_

Instructions provided by your **doctor** are needed in order for your child to take **prescription medication** at school. Over the counter medication (such as Tylenol) only requires parent instructions and permission signature.

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:

| MEDICATION | DOSE (START DATE./STOP DATE) | TIME  | DIRECTIONS |
|------------|------------------------------|-------|------------|
| _____      | _____                        | _____ | _____      |
| _____      | _____                        | _____ | _____      |
| _____      | _____                        | _____ | _____      |
| _____      | _____                        | _____ | _____      |
| _____      | _____                        | _____ | _____      |

Diagnosis or reason for medication  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_

**All medications must be delivered to school AND picked up from the school by the parent/guardian. The medications will be stored in the school office (with the exception of inhalers as permitted by the physician.)**

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: \_\_\_\_\_

