

2011-2012
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: _____

