

PERMISSION FOR NON-PRESCRIPTION MEDICATION TO BE TAKEN AT SCHOOL

Name of student: _____

Name of school: _____ Grade _____ Teacher: _____

Name of medication: _____ Dosage: _____

Purpose of medication: _____

Time of day, or how often medication may be taken: _____

Possible side effects: _____

Anticipated number of days it needs to be taken at school: _____

I hereby give my permission for _____ to take the above medication.

Signature of parent

Date

NOTE: MEDICATION IS TO BE BROUGHT TO THE SCHOOL BY A PARENT OR OTHER RESPONSIBLE ADULT, IN THE ORIGINAL CONTAINER.

Prescription medications are required to have a form signed by the physician. (See PHYSICIAN ORDER)