

## PERMISSION TO ADMINISTER MEDICATIONS IN SCHOOLS

Student's Name\_\_\_\_\_

Name of Medication\_\_\_\_\_

Doctor's Name\_\_\_\_\_

Reason for Medication:

Length of time medication needed:

Dosage (amount and when given):

Possible acute side effects:

I give my permission for school personnel to administer the above medication.

Signature of Parent/Guardian\_\_\_\_\_

Date\_\_\_\_\_