Parent Permission to Medicate

This form must be complete by parent/guardian in order to administer medication to the following student. Routine medications must require a monthly parental initial verification. Over the counter medications require parental initial verification on the day administered. ***Please note that over the counter medications require a physician's signature.***

Child's Name_____ Parent's/Guardian Name _____

Medication_____ Prescription Number _____

Times of day medication is to be given _____ A.M._____ P.M. _____

Method of giving dosage _____

Amount of each dosage _____

Date from _____ to _____ Reason for medication _____

Allergies _____

Person designated to administer medication _____

Parent/Guardian Signature _____ Date _____

Physician Signature _____ Date _____
(Required for prescription & over the counter medications.)

Please review "Medication During Program" information in parent handbook.

Date	Time	Health Problem/Concern	Care Provided	Staff Signature	Verifying Initials