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.

Child's Name			Parent's/Guardian Name				
Medication			Prescription Number				
Times of da	ay medicatio	on is to be given		A.M	P.M		
Method of	giving dosag	je					
		e					
Date from to Reason for medication							
			·				
		dminister medication					
Parent/Gua	ardian Signa	ture	Date				
		_		Date			
,	<u> </u>						
Data	Timo	Hoalth Problem/Concorn	Caro Provided	Stoff Signatur	ro	Verifyir	

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