

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
Aspirin	123456789
Ibuprofen	987654321
Acetaminophen	567890123
Amoxicillin	345678901
Penicillin	234567890
Metformin	012345678
Lisinopril	890123456
Atorvastatin	789012345
Simvastatin	678901234
Warfarin	456789012
Heparin	345678901
Insulin	234567890
Levothyroxine	123456789
Sertraline	987654321
Fluoxetine	876543210
Escitalopram	765432109
Clonidine	654321098
Diltiazem	543210987
Nifedipine	432109876
Verapamil	321098765
Amlodipine	210987654
Losartan	109876543
Valsartan	098765432
Enalapril	987654321
Lisinopril	876543210
Atorvastatin	765432109
Simvastatin	654321098
Warfarin	543210987
Heparin	432109876
Insulin	321098765
Levothyroxine	210987654
Sertraline	109876543
Fluoxetine	098765432
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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 _____

[illegible]

