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 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 _______________

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