

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 _____

[illegible]