## 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 Nam	Parent's/Guardian Name			
Medication		Prescription	Prescription Number			
Times of day me	dication is to be g	given	A.M	P.M		
Method of giving	dosage					
Date from	to	Reason for medication				
Allergies						
Person designate	ed to administer r	nedication				
Parent/Guardian	Signature		Date			
			Date			
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Date	Time	Health Problem/Concern	Care Provided	Staff Signature	Initials
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