Parental Permission for Administering
Prescription Medication

The following information is to be completed by the PARENT for non-prescription medication and will be kept in school files.

Date ___________________________

Child's Name ____

Medication ____

Amount of dose ____________ Time ___________ Prescription # ___________

My child's medication is in the labeled prescription container. I request that authorized staff make provisions for my child to receive the medication as the doctor as prescribed.

______________________________________ ___________________________
Parent's or Guardian's signature Phone