

Permission to Administer Medication

Student Name: _____

Name of Medication: _____

Dosage: _____

Time to be given: _____

Dates to be given: _____

Parent's Signature: _____

*** Please fill out a medication form for each medication to be given. A form must be filled out for over-the-counter and prescription medications. The medication must be in the original container or prescription bottle, and labeled with the name of the student and the name of the medication. All medications brought to school must be left with the teacher for elementary and preschool students and in the office for junior high and senior high students. Students must come to the teacher/office to take their medicine. *The school does not have Tylenol available to students.* ***

<i>(Office Only)</i>	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>
Name of Medicine					
Dosage Given					
Time Given					
Date Given					
Signature					
Name of Medicine					
Dosage Given					
Time Given					
Date Given					
Signature					
Name of Medicine					
Dosage Given					
Time Given					
Date Given					
Signature					
Name of Medicine					
Dosage Given					
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Date Given					
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