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