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