Parental Permit to Administer Medication at School for 6 weeks or Less

Permit Expires _______________

Student Name: Last	First	MI	Grade	Student ID

Prescription Medication	**Non-Prescription Medication**
Name of Drug	Name of Drug
Time to be given	Time to be given
Amount to be given	Amount to be given

Reason medication being given			
Tablets	Capsules	Liquid	Other

I give permission for this medication to be given at school under the direction and supervision of the school nurse.
I understand that all medication must be in a properly labeled, original container.

Parent/Guardian signature	**Date**

Date	**Time**	**Dose**	**Signature**