

PERMISSION TO DISPENSE MEDICATION

Parent's Authorization

Administer the following medication to:

Name of Student: _____

Prescribing Physician: _____

Prescription Number: _____

Name of medication: _____

Dosage: _____

When to give medication: _____

Continue this medication until (date): _____

**MEDICINE MUST BE IN ITS ORIGINAL CONTAINER
WITH THE STUDENT'S NAME CLEARLY WRITTEN.**

**NO MEDICATION WILL BE GIVEN TO STUDENTS
UNTIL THIS FORM IS RETURNED.**

Signature of Parent/Guardian

Date

Please return to Brenda Craig