PERMISSION TO DISPENSE MEDICATION

Parent's Authorization

Administer the following medication to:

Student Name: _____

Prescribing Physician: _____

Prescription Number: _____

Name of medication**: _____
Dosage: _____

When to give medication: _____

Continue this medication until (date): _____

_____ _____
Parent/Guardian Signature Date

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

NO MEDICATION WILL BE GIVEN TO STUDENTS WITHOUT THIS SIGNED FORM.