PARENTAL PERMISSION TO ADMINISTER MEDICATION AT SCHOOL
2026-2027

Student Name _____Date of Birth_____

Parent/Guardian Name(s) _____

Home Phone # _____ Cell Phone #_____ Work # _____

I REQUEST THAT THE FOLLOWING MEDICATION(S) BE ADMINISTERED TO MY CHILD BY SCHOOL NURSE.

Name of Medication #1: _____
Condition for which medication is to be given: _____
Amount of medication to be given: _____Time to be given: _____
Medication is to be given (choose one):

_____ every day
_____ as needed
_____ for a short period only
_____ from _____ to _____
(date) (date)

Possible side effects _____
Prescribed by: _____Doctor's phone # _____

Name of Medication #2: _____
Condition for which medication is to be given: _____
Amount of medication to be given: _____Time to be given: _____
Medication is to be given (choose one):

_____ every day
_____ as needed
_____ for a short period only
_____ from _____ to _____
(date) (date)

Possible side effects _____
Prescribed by: _____Doctor's phone # _____

I understand that this medication will be furnished by me in its original container and be given to a designated school staff member. I will notify the school in writing if the medication has been discontinued or the dosage changed. The first dose of any medication will be given at home so that parents can monitor adverse reactions.

Signature of Parent/Guardian **Date**