

**PERMISSION TO ADMINISTER ORAL MEDICATION IN SCHOOL**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Classroom Teacher: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Instructions for administering medication at school.:

Name of Medication	Dosage	Time to be Administered	Begin (Date)	End (Date)

Please indicate purpose of Medication listed above and possible side effects.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date Contacted: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorizing administration of medications indicated above.

Bring this form and medication to the classroom teacher. Medications will be dispensed by the classroom teacher.