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.

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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.