For school use:
‘ Routine
‘ PRN
Start Date: _________

SCHOOL HEALTH SERVICES
Permission for Medication

____ ____________________ ________________
6WXGHQW¶V Name | Date of Birth | Grade

Medication:	Dosage:	Route:
Purpose of Medication:		
Time of day medication will be given at school:	Frequency: (e.g. daily)	Allergies to food, medicines, or other items? ☐NO ☐YES List allergies :
Anticipated number of days medication will be given at school: ☐Until the end of the current school year ☐______weeks ☐______days		Is this medication a controlled substance? ☐NO ☐YES
Possible Side Effects:		

Health Care Provider Authorization

3UHVFULELQJ +HDOWK &DUH 3URYLGHU¶V 6LJQDWXUH (Required if Prescribed Medication)	Date:
,QVHUW 3URYLGHU¶V 1DPH DQG $GGUHVV 6WDPS %HOR	Office Phone Number: Office Fax Number:

Parent Authorization

I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to GLVFXVV WKLV PHGLFDWLRQ DQG P\ FKLOG¶V KHDOWK , JLYH SHUP