



## MEDICATION PERMISSION FORM

School Year: \_\_\_\_\_

Student name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**This section to be completed by the student's physician:**

Name of medication: \_\_\_\_\_

Dosage of medication: \_\_\_\_\_

Frequency and time for administration of medication:

\_\_\_\_\_

How medication is to be administered:

\_\_\_\_\_

Date of prescription and order:

\_\_\_\_\_

Diagnosis requiring medication:

\_\_\_\_\_

Intended effect of medication:

\_\_\_\_\_

Possible side effects:

\_\_\_\_\_

Other medication student is receiving: \_\_\_\_\_

Doctor's name (print): \_\_\_\_\_

Doctor's Telephone number: \_\_\_\_\_

Doctor's signature

\_\_\_\_\_ Date \_\_\_\_\_

**This section to be completed by the student's parent:**

I hereby give permission for a member of the school staff to assist my child in taking the above-prescribed medication in the manner described.

Daytime phone number: \_\_\_\_\_

Parent signature

\_\_\_\_\_ Date \_\_\_\_\_