

**M E D I C A T I O N S**

**Parental Permission for  
Administration of Non-prescription Medication  
(To be returned to the School Nurse/Associate School Nurse)**

I hereby give my permission for:

Name of Student \_\_\_\_\_

in grade \_\_\_\_\_ at \_\_\_\_\_ School

to take:

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Directions \_\_\_\_\_

Reason for Giving \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

No non-prescription medication will be given at school until the school receives this completed form with the medication provided in its original container.

All medicine brought into the school must be kept in the health room during school hours.

Date Received: \_\_\_\_\_

Signature of School Nurse: \_\_\_\_\_

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