Parent Permission for Administration of Non-prescription Medication (To be returned to the 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____________________________________