PERMISSION for the ADMINISTRATION OF MEDICINE

This form is to be filled out completely whenever medicine is to be administered to your child during school hours. Be specific with the "Start" and "Finish" dates for administering medicine, for the staff follows those dates precisely. Please remember to pick up your medicine bottle(s) when your child is no longer in need of it or they will be discarded. There are extra forms in the upper hall outside the main office.

ALL medicines, prescriptions and non-prescriptions, must be in the original containers with the label intact and legible. The medicine bottle MUST have the child's name CLEARLY marked before administered by our staff. Please include a spoon or medicine cup.

CHILD'S NAME_____ TEACHER_____

DOCTOR'S NAME & PHONE_____

MEDICATION(S) to be ADMINISTERED_____

_____

LOCATED IN: _____REFRIG _____GRAY CABINET

DOSAGE_____ HOW_____

START DATE_____FINISH DATE_____

CIRCLE time(s) for dosage* 12:00 4:00

*Medicines will be given ONLY at the above times.

FOR OFFICE USE ONLY:
Date / Time / Intls. Date / Time / Intls.

_____
Parent's Signature

_____
Staff Signature