# Medication Permission Slip

PHYSICIAN'S AND PARENT REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

**MEDICATIONS ARE NOT PROVIDED BY THE SCHOOL**
**MEDICATIONS PURCHASED IN A FOREIGN COUNTRY CAN NOT BE GIVEN**

**Name of Student _____ D.O.B. _____**

**Grade _____ Teacher _____**

Condition for which medication given _____

| Medication | Dosage | Time | Pill Count | Nurse's Initials |
|---|---|---|---|---|
| 1. _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ |

I request the above medication(s) be given to my child by the school nurse or principal-designated staff member.

I give the school nurse permission to contact the prescribing physician with any questions relating to the above medication. **Please initial** _____.

**Physician _____ Phone _____**

**Physician's Signature _____ Date _____**

All medication will be discarded at the end of the school year if not picked up by the parent by the last day of school. **Please initial** _____ (please call 978.649.7611, Ext. 329 for pick-up arrangements.)

**Parent Signature _____ Date _____**

**Parent Phone Number _____ Parent Cell Phone _____**

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Office use only:

Medication picked up by _____ Date _____

Medication disposed of by _____ Date _____