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 _____

Office use only:

Medication picked up by _____ Date _____

Medication disposed of by _____ Date _____