

MEDICATION ADMINISTRATION PERMISSION SLIP

DATE: _____

CHILD'S NAME: _____ **GRADE:** _____

MEDICATION:* _____

DOSAGE: _____

TIME: _____

****ALL medications, including over the counter, herbal supplements and homeopathic preparations, require a doctor's order, which includes the dose, and times to be given in order to be administered in school.***

Medications must be delivered by a parent/guardian in the original container properly labeled. Students are not permitted to carry medications while in school with certain exceptions. Those who need inhalers, Epi-pens, etc. must have a Self-Administration form completed and returned to the Health Office. Please contact the Health Office with any questions.

Doctor's signature: _____

Parent/Guardian's signature: _____

A consent form is required every year.

Check one:

_____ ***I will pick up unused medicine.***

_____ ***Please discard unused medicine.***