

M E D I C A T I O N S

**Parental Permission for
Administration of Non-prescription Medication
(To be returned to the School Nurse/Associate 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: _____
