Prescription Medication Permission Form

To be completed each school year!

TO BE COMPLETED BY PARENT/GUARDIAN

Student First & Last Name:	Date of Birth:
2019/2020 Teacher:	2019/2020 Grade:

I am requesting that my child receive **prescription** medication as designated below.

I will be responsible for bringing the medication to school EACH SCHOOL YEAR in its accurately labeled container to avoid any interruptions of the medication administration. Failure to do this will result in termination of medication administration program.

I understand that, if my child refuses to take the medication, force will not be used by school personnel to make my child comply.

Parent/Guardian's Printed Name	Permission Effective Through Date*
Parent/Guardian's Signature	Today's Date

**UNLESS discontinued, changed by me, or withdrawn in writing by child's legal parent/guardian.*

TO BE COMPLETED BY HEALTH CARE PROVIDER

Child's First & Last Name:	Date of Birth:

Medication (Generic & Trade Name)	Dosage	Time of day / Frequency	Possible/Common Side Effects

I am prescribing the medication(s) as described for the child listed above.

Health Care Provider's Printed Name	Orders Effective Through Date*
Health Care Provider's Signature	Today's Date
Name of Health Care Provider's Office	Phone Number

**UNLESS discontinued, changed by me, or withdrawn in writing by child's legal parent/guardian.*