

Medication Permission Form

Prescription and Nonprescription

Child's Name: _____ Class: _____

Parent Signature: _____ Date: _____

Parent Phone Number: _____ (Just in case we need to contact you)

Name of Medication: _____ Requires Refrigeration: Y N

Condition for which prescribed: _____

Possible side effects: _____

IF PRESCRIPTION

Pharmacy: _____ Phone: _____ RX# _____

INSTRUCTIONS:

DOSAGE AMOUNT: _____ Begin Date: _____ End Date: _____

Time of day to be administered: _____

DAYSCHOOL STAFF: Fill in date, time and initial whenever dispensing medicine.

DISPOSITION OF MEDICINE: Date returned to parents: _____ Teachers initials: _____

Monday	Tuesday	Wednesday	Thursday	Friday

PLEASE RETURN THIS FORM TO THE DAYSCHOOL OFFICE ONCE MEDICATION IS COMPLETE