# PERMISSION FOR NON-PRESCRIPTION MEDICATION TO BE TAKEN AT SCHOOL

Name of Student:_____

Name of School:_____Grade:_____ Teacher:_____

Name of Medication:_____ Dosage:_____

Purpose of Medication:_____

_____

Time of day, or how often medication may be taken:_____

_____

Possible side effects:_____

Anticipated number of days it needs to be taken at school:_____

_____

Additional instructions:_____

_____

I hereby give my permission for _____ to take the above
*student's name*

medication at school as stated. I understand that it is my responsibility to furnish this medication.

_____

Signature of Parent or Guardian Date

**Note: Medication is to be brought to school by parent or other responsible adult, in the ORIGINAL CONTAINER.**
Prescription medications are required to have a form signed by the physician (see PHYSICIAN ORDER).