Christ
the Divine Teacher
School

PARENT/GUARDIAN ADMINISTRATION OF MEDICATION PERMISSION FORM

This permission form must be accompanied by written instructions from the attending physician.

Please complete the following information and enclose with each medication you send to school to be taken during school hours.

Student name: _____ Grade: _____ Homeroom: _____

Name of medication: _____

Prescribed by physician? Yes ____ Name of physician: _____

Include the doctor's written instructions with your permission form.

Prescription number: _____ Name of pharmacy: _____

Dosage: _____ at _____times for _____ days.

LIST ALL CURRENT MEDICATIONS TAKEN BY THE STUDENT (home or school):

_____

_____

I will take full responsibility for the prescribed mediation which is to be given during school hours.

Signature of Parent or Guardian: _____ Date: _____

Cell phone: _____ Home phone; _____ Work phone: _____

Note:

The medication container must be properly labeled with the student's name, homeroom, name of the medication and the time and dosage to be given.

Medications that do not comply with these guidelines will not be given by school personnel and will be returned to the parent or guardian.