

PARENTAL MEDICINE PERMISSION FORM

THIS PERMISSION FORM MUST
BE ACCOMPANIED BY THE
PRESCRIBED MEDICATION

Use complete the following information and enclose it
with each medicine you send with your child to be taken
during school hours. Please do not omit any information.

STUDENT NAME _____ GRADE _____ ROOM# _____

TYPE OF MEDICINE _____

PRESCRIBED BY PHYSICIAN? YES _____
(PHYSICIAN NAME) _____

Prescription No. _____ Name of Pharmacy _____

Age _____ at _____ for _____ days
(times) (number)

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

NATURE OF PARENT/GUARDIAN _____

Home PHONE _____ (HOME) _____ (BUSINESS)

MEDICINE CONTAINERS MUST BE LABELED WITH THE NAME
OF THE STUDENT, THE AMOUNT TO BE TAKEN, AND THE TIME
IT IS TO BE TAKEN.

ADDITIONAL INFORMATION (IF ANY) IS PRINTED ON THE REVERSE SIDE OF
THIS FORM)