Medication Dispensing – In-School Permit

To be completed by a parent or guardian:

I authorize the School Nurse to see that my child ___________________________ receives the medication prescribed by Dr. ___________________ for the school year from ___________ to ______________.

This medication is to be in a labeled container with the name of the medication, the amount to be given, time to be given, the name of the student and the prescribing physician’s name on the label.

Signature of parent/guardian: ______________________________

To be completed by the physician:

Name of medication: __________________________________________

Dosage of medication: _________________________________________

Time of Administration: ________________________________________

Special instructions: ___________________________________________

Signature: ___________________________________________________

Physician, Dentist, Nurse Practitioner, etc.

Date: __________________________