PERMISSION FORM FOR MEDICATION

Name of Student: ____

Grade:____________ Teacher______________________________________

To be completed by physician or parent:

Reason for medication: (All medication must be in the original container.)

Name of medication:

___ Tablet/capsule ___Liquid ___Inhaler ___ Oral application

Starting date:________________________Ending date:_____________________

This student is both capable and responsible for self-administering this medication:

___yes ___no

Date:_____________Signature:______________________Relationship:_______