PERMISSION FOR NON-PRESCRIPTION MEDICATION TO BE TAKEN AT SCHOOL

Name of student: ____

Anderson 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: ________________

I hereby give my permission for ____________________to take the above medication.

____

Signature of parent Date

NOTE: MEDICATION IS TO BE BROUGHT TO THE SCHOOL BY A PARENT OR OTHER RESPONSIBLE ADULT, IN THE ORIGINAL CONTAINER.

PRESCRIPTION MEDICATIONS ARE REQUIRED TO HAVE A FORM SIGNED BY THE PHYSICIAN. (SEE PHYSICIAN ORDER)