Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ **DOB:** _____

Grade: _____ **Teacher/HR:** _____ **School:** _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

1. **Name of Medication:**

   _____

2. **Name of Medication:**

   _____

3. **Name of Medication:**

   _____

Parent/Guardian Signature: _____ **Date:** _____

Email: _____

Phone Where We Can Reach You: _____ ☐ **Check if Cell**

Return to:

School Nurse: _____

School Address: _____ Fax _____

Phone: _____ Email: _____