Medication Permission Form (Optional)

Child's First and Last Name_____

Please fill out a separate form for each child keeping medicine at school.

_____**I'm turning in the following medication to be kept in the school office and administered as needed.**

Name of Medication(s):_____ Dosage Amount:_____

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For circumstances that require immediate attention:

_____ I am requesting that the above medication be kept in the classroom and administered by my child/teacher as needed.* *(example: rescue inhaler for asthma)*

Please explain:_____

Note:* ***IF THE TEACHER* *is asked to administer medication (they can, by law refuse).*

If the medicine EXPIRES during the school year, please select one of the following options:

_____Dispose of the medicine at school _____Send the medication home with my child

I understand that all medications not picked up by the end of the school year will be discarded in June!

_____ _____

Parent Name (please print) Parent Signature Date

CC: Nurse Office, Homeroom Teacher