Eccles School

Permission to Administer Medication

Student Name _____Date received_____

To be completed by parent/doctor:
Name of Medication _____Dosage _____
Reason for Medication _____
Form of Medication: tablet/capsule/inhaler/injection/liquid/other_____
Times(s) to be given at school _____

Start Date: _____
Stop Date: _____

Side effects/adverse reactions teacher and aides should watch for while student is taking this medication

_____
Special storage requirements

_____

Please provide any additional information

_____
_____
Parent or doctor signature

_____
Date _____

Health care provider name _____
Phone number _____

To be completed by parent/guardian:

I request that _____ receive the above medication at school according to school policy and for the physician('s) staff and school district staff to share information needed to assist my child with medication needs. I will provide the school with my child's medications in its original container (pharmacy or over-the-counter). I have received a copy of the school medication administration policy.

Signature _____
Relationship _____
Date _____