Permit to Administer Medication

Please fill one out for each medication whether prescribed, OTC or herbal
Unless prescribed, youth shall not have medications with them.

Student Name_____

Name of Medication _____

Amount to be Given _____ Dates to be Given _____

Time of day to be given _____

Reason for Medication _____

_____

Side effects of medication _____

_____

Emergency response to Medication _____

_____

Any other concerns _____

_____

_____ _____

Signature of Parent Phone where you can be reached