

**Cassville R-IV School
Health Services**

MEDICATION ADMINISTRATION PERMISSION FORM

Name of ChildTeacherGrade

I hereby request and give permission to the school nurse or other person authorized, to administer the following medication to my child:

Name of MedicationDosage

at _____ starting on _____ and stopping on _____

TimeDateDate

Does this medication need to be refrigerated? Yes No

Medication must be brought to school in the original container as dispensed by the pharmacist or physician.

- o If any revisions in the above request occur, a written revised statement must be submitted to the school before the change will occur.
- o The school nurse is given my permission to confirm with the child's physician the medication or dosage at her discretion.
- o It is the student's responsibility to come to the nurse's office for the medication unless he/she is physically unable to do so.

Parent/Guardian SignatureDate

Physician's NamePhone Number