School Year 2021-2022

PERMISSION FOR ADMINISTERING MEDICATION

I hereby give permission for my child _____ to receive medication/tube feeding(s) at school during hours as prescribed by his/her physician.

_____

(Physician's Name) (Telephone)

_____

(Parent/Guardian Signature) (Date)

Please request from your doctor a written order for any medication/tube feeding(s) your child requires during school (9 a.m. – 2:45 p.m.). You may use the form below. **Please complete one form for each medication, tube feeding, or PRN medication.**

Student: _____

Diagnosis: _____

Type of Medication/Formula: _____

Dosage: _____

Route of Administration: _____

Time of Administration: _____

Physician Signature: _____

Date: _____

Note: The administration of medication will not be changed in any way unless a new form is submitted and signed by the attending physician.