

Permission to Medicate

This form must be completed by your physician and returned to the school.

Your child's medication (prescription and non-prescription) should be registered with the school administration and/or nurse. All medication should be in the original container and must be properly labeled with the student's name, physician's name, date of prescription, name of medication, and dosage.

Student's Name _____ Grade _____ Date of Birth _____

Medication _____

Reason for Taking this Medication _____

Dosage _____ Time(s) to Administer _____

Prescribing Doctor _____ **Doctor's Phone** _____

Pharmacy _____ Prescription No. _____

Special Instructions _____

Please give the medication listed above for _____ days beginning _____ (but not to exceed one school year).

(1) PHYSICIAN'S AUTHORIZATION

Printed Name of Prescriber

Signature of Prescriber

Date

(2) PARENT/LEGAL GUARDIAN'S AUTHORIZATION

I authorize the school to assist my child in taking the above medication and I agree that I will not hold liable any member of The Paideia Academy staff who is directed by me and the administration to assist my child in taking the medication.

Parent/Legal Guardian's Signature

Date

