2018–2019 Medication Form

Child's Name: _____ DOB: _____ Grade: _____

Physician's Name: _____

Telephone #: _____

☐ I give permission to the School Nurse to administer the following medication to my child during school hours:

Medication: _____

Dosage: _____

Frequency: _____

Special Instructions/Comments: _____

_____

Medication: _____

Dosage: _____

Frequency: _____

Special Instructions/Comments: _____

_____

Medication: _____

Dosage: _____

Frequency: _____

Special Instructions/Comments: _____

_____

I give permission for this information to be shared with Tower faculty and staff as deemed necessary by the School Nurse.

Parent Signature: _____ Date: _____