School Medication Administration Permission Slip

Student Information

Student Name

Date of Birth

Grade

Teacher / Homeroom

Parent/Guardian Name

Medication Information

Medication Name

Dosage

Time(s)/Frequency

Route (e.g., oral, topical)

Purpose of Medication

Possible Side Effects

Special Instructions

Start Date

End Date

Parent/Guardian Permission

I hereby give permission for school personnel to administer the above medication to my child as directed. I understand that it is my responsibility to provide the medication in the original, labeled container.

Parent/Guardian Signature

Date

Phone Number

Physician Authorization (if required)

Physician Name

Phone Number

Additional Physician Instructions

Physician Signature

Date