

## PERMISSION TO ADMINISTER MEDICATION

Student: \_\_\_\_\_

D.O.B. \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

Date: \_\_\_\_\_

### To Be Completed by Parents / Guardian

I hereby give permission for Lewis Central School to administer medication as prescribed below to my child \_\_\_\_\_. During the school hours, it is my understanding that a licensed nurse or medication certified staff will administer the prescribed medication according to physician's orders to my child. Your signature on this form will give us permission to contact this prescriber if we feel it is necessary.

\_\_\_\_\_  
Parent's Signature

---

### To Be Completed by Physician

Medication: \_\_\_\_\_

Recommended Dosage: \_\_\_\_\_

Time(s) to be administered: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

\_\_\_\_\_  
Prescriber's Signature

---

Thank You,

Nurse / Health Associate

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_