

**DAY SCHOOL
PERMISSION TO ADMINISTER MEDICATION**

Today's Date ____/____/____

Child's Name _____

Teacher's Name _____

Parent Contact: Day Phone _____ (Mom)

Day Phone _____ (Dad)

Physician's/Clinic's Name _____

Physician's/Clinic's Phone (_____)_____-_____

MEDICATION

Name of medication _____

Is this a prescription medication? Yes _____ No _____

Prescription number _____

IMPORTANT: All medication must be accompanied by this form, and in the original container.

DOSAGE

Date to begin medication ____/____/____ Date to end medication ____/____/____

Amount to administer _____

Time to administer ____:____ a.m. ____:____ p.m.

NOTES: _____

Please use the back of this form for additional information

I give permission to Westminster Schools to administer the medication described above to my child in the dosage specified.

Parent Signature _____ Date ____/____/____