

**UPPER SCHOOL
PERMISSION TO ADMINISTER MEDICATION**

Child's Name _____

Parent _____ Phone _____

OVER-THE-COUNTER MEDICATION
As-needed Basis

Name of medication _____

Amount to administer _____ Interval _____

PRESCRIPTION MEDICATION

Prescription name/number _____

Amount to administer _____ Interval _____

Date(s) to administer medication _____

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

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

Parent Signature _____ Date _____