2018-19 Permission to Administer Medication

Child's Name ______________________________ Grade ____________

Parent's Name ______________________________ Phone ____________

OVER-THE-COUNTER MEDICATION (OTC)

(As-needed Basis)

Name of Medicine	**Dosage** (milligrams)	**How Often to Administer**	**Comments** (take w/food; on empty stomach; am/pm; etc.)

PRESCRIPTION MEDICATION

Name of Medicine	**Dosage Amount**	**How Often to Administer**	**Dates to Administer**	**Comments** (take w/food; on empty stomach; am/pm; etc.)

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

Please remember that students are NOT permitted to keep medication on their person or in their lockers, purses, backpacks or vehicles with the exception of rescue devices such as inhalers or EpiPens. Duplicates of these should also be in the office.

Parent's further instructions/comments ______________________________

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I give permission to Westminster Schools of Augusta (WSA) to administer the medication(s) described above to my child in the dosage specified. I will advise WSA of any changes/updates to the information above.

Parent Signature ______________________________ Date ____________