VICTOR SCHOOL
PERMISSION FOR PRESCRIPTION MEDICATION

Name of Student:____

Teacher:_____________________________________Grade:__________

Medication:____

Dosage:____

Purpose of Medication____

____

____

____

Time of day medication is to be given:______________________________

Possible side effects:____

____

____

____

Number of days medication will be given at school____________________

Date:______________

Physician Signature:____

____

I hereby give my permission for my child_____________________________
to take the above-named prescription medication in a duplicate medicine bottle labeled by the physician or pharmacist in a single, daily dose. I certify that my child has had at least one dose of this medication and has shown no apparent reaction to it.

Date:_______________

Parent/Guardian Signature:_______________________________________