

SCHOOL HEALTH OFFICE

Hillside Elementary School

Date: _____

I _____ as the parent/guardian or responsible party, would like _____ a student in the _____ grade to be allowed to take the following medication as needed.

Medication: _____

Frequency: _____

Dose: _____

Reason: _____

I give my permission to allow School Staff to administer this medication if the Nurse is not available Parent/guardian or responsible party initial: _____

Parent/Guardian:

Print: _____

Sign: _____

Date: _____