# Permission to Administer Medication Form
# School Year 2014-2015

Child's Name: _____

Name of Medication: _____

Date(s) to be Given: _____

Time to be Given: _____

Amount to be Given: _____

Special Instructions: _____

_____

Parent Signature: _____

Doctor Name Printed: _____

Doctor Signature (required): _____

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For Office Use Only:

| Date | Administered By | Time | Dosage Given |
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