



MEDICATION PERMISSION FORM 2016

Dear Parents,

Under our guidelines for distribution of medication for children who need to take medication at school the following information is required for the class teacher. Please fill in the details, sign the form and return to the teacher as soon as possible.

Name of Child:..... Grade:.....

Classroom Teacher:.....

Name/Type of Medicine:.....

Dosage of Medicine:.....

Time Medication is Required: (Please tick)

- Daily
- Weekly
- Other

Include actual time/s

.....

I hereby give approval for my child to receive the above medication as outlined and accept that the teacher will be given my permission to securely store the medication for my child and distribute it according to the above information.

Parent/Guardian Name:.....

Signed:.....

Date: / /2016