Parent/Guardian Authorization to Administer Medication

Student Name: ______________________ DOB__________ Grade ____

Name of Medication:____

Check one: _______Prescription _______ Non-Prescription

Dosage/Route: ____

How often:____

Parent/Guardian administer medication at:_________________________

Date to begin: _________________Date to end: ___________________

REQUIRED

Parents Name______________________________

Parents Signature___________________________ Date: ______________

By signing this permission form I give Clarkfield Area Charter School permission to administer medication to my child listed. Medication will always be in original bottle and will be administered according to label directions.