Medication Information/Permission Form

Student Name:

Date:

Grade:

Teacher:

Medication:

Dosage:

Time to administer medication:

Doctor/Phone #:

Please check one of the following options that applies to your child:

- ❑ I am requesting and giving permission to ZCS/my child's teacher to handle (store, administer) the medication of my child.
- ❑ My child is on medication which must be taken at school. My child will be fully responsible to take his/her medication. I understand that my child may only take one day's amount of medication to school per day,

____

Parent/Guardian Signature Date

updated 8/2018