Permission to Medicate 2024-2025 School Year

This form is only valid for the 2024-2025 School Year and one medication at a time.

Child's Last Name:_____ **Child's First Name:**_____

Room Number:_____ **Teacher:** _____

INSTRUCTIONS:

Name of Medication:_____

Please Check Accordingly: ☐ Doctor's Prescription ☐ Over-the-Counter ☐ Needs Refrigeration

Dosage: _____**Route:** _____

Reason for Medication: _____

Possible Side Effects:_____

Check the appropriate days to administer medication:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time(s) medication to be given: _____am _____pm

Other (Before/After Lunch, etc.): _____

_____

Complete if applicable: Medication can be given _____ minutes early or late.

Medication administration will be entered electronically into Procare. If unavailable, medication administration will be entered below.

Time & Date	Staff Responsible	Time & Date	Staff Responsible	Time & Date	Staff Responsible

Parent Signature: _____ **Date:** _____

School Nurse Signature: _____**Date:** _____

For Parent/Guardian Use Only: Was medication returned at conclusion of treatment? ☐Yes ☐No

Parent/Guardian Signature: _____

High Hopes
DEVELOPMENT CENTER

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