CHANDLER PUBLIC SCHOOL

MEDICATION PERMISSION FORM
For Medications To Be Taken At School

_____

Patient's Full Name

_____

Medication and Dosage

_____

Diagnosis

_____

Signature of Parent/Guardian

The above named student has a health condition that requires his/her taking medication during school hours.

Directions for taking medication:

Amount:_____

Time:_____

Number of Days:_____

Physician's Signature_____ Date_____

Administration of Medication Permission and Log Sheet

Patients Name_____

Medication and Dosage_____

Diagnosis_____

Parent/Guardian's signature_____

Directions for taking medication:

Amount_____ Time_____

Beginning Date_____ Number of Days_____

Physician's Signature_____ Date_____

Date/Time of Dosage	Medication and Dosage	Given by (Signature)

Caution!

Positively identify this student and be certain that the correct medication and dosage is given.