

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 (Signature)	Medication and Dosage	Given By

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