ST. PAUL'S SCHOOL PERMISSION TO ADMINISTER MEDICATION

Student's Name: ______________________________

Date: ______________________________

Time: ______________________________

The above student is experiencing the following symptoms, and I would like for him to take this medication to help control these symptoms so that he can remain at school.

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An employee of St. Paul's school has my permission to administer the following medication to my child during school hours. My child has taken this medication in the past and has experieced no side effects.

Parent's/Guardian's Signature: ______________________________

Medication: ____________________ Dosage: __________

Medication: ____________________ Dosage: __________

Medication: ____________________ Dosage: __________

Medication: ____________________ Dosage: __________

Administered by: ______________________________