ALMADEN COUNTRY DAY SCHOOL

Permission to Take Medication Form

To be completed by PARENT or GUARDIAN:

Student Name: _____Grade: _____

I authorize my child to take the medication described below:

Medication: _____Dosage: _____

Method for taking: _____Time schedule: _____

Reason for medication:_____

Where medication is to be stored at school (circle all that apply):

Office Homeroom

I understand it is my responsibility to provide the school with over-the-counter medication in its original packaging, clearly labeled, and/or prescribed medication in a pharmacy-labeled container with my child's name and the dispensing instructions. Medicine cannot be expired. I understand that school personnel may not administer the medication*. While the school will make every effort to cooperate, my child must assume responsibility for obtaining the medication from the office personnel or his homeroom teacher. My child will not possess any medication during the school day or on a field trip but will give any medication to the Office Staff or the field trip chaperone, except as noted above.

Print Name: _____ Date: _____
Parent or Guardian

Signature: _____
Parent or Guardian

Permission must be obtained for each medication.

* In the event of an allergy emergency, school personnel may administer an Epi-Pen.

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