MEDICATION ADMINISTRATION PERMISSION FORM

DATE_____

CHILD'S NAME _____

DATE OF BIRTH: _____

MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

We give our permission for the above medication to be administered by the school nurse at Parkview Elementary School.
Forms can be faxed to: 856-456-5974.

Doctor's Signature: _____
(Prescription MUST be brought to school by a parent or guardian.)

Phone Number: _____

Office Stamp:

Parent Signature: _____

School RN Signature/Date Received: _____

Rev. 11/22