

THE SUMMIT COUNTRY DAY SCHOOL

2161 Grandin Road

Cincinnati, Ohio 45208

 **Parent Permission for Medication Administration**

|  |  |
| --- | --- |
| **Students name** | **Birthdate** |
|  |  |
| **Address** | **Grade** |
|  |  |
| **Allergies** | **Phone** |
|  |  |
|  |
| **Medication** | **Dose** |  |
|  |  |  |
| **Time(s) to be given:** |
|  |
| **Special instructions for administration:** |
|  |
|  |
|  |
| **Start Date:**  | **End Date:**  |
|  |  |
|  |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Guardian) give permission for authorized school personnel to administer the over the counter medication as listed above to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(child’s name), and further agree to the following:* Deliver medication to school in the original container.
* Notify school if the medication is changed or discontinued.
* Parent/Guardian is to pick up any remaining medication on the end date. Medication not picked up will be discarded.
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| **Parent/Guardian Signature** | **Date** |
|  |  |