

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. | | |
| **Parent/Guardian Signature** | **Date** | |
|  |  | |