## **Medication Permission Form (Optional)**

Child's First and Last Name	out a separate form for each child keeping me	dicine at school.
I'm turning in the following medicatio	n to be kept in the school office and administ	ered as needed.
Name of Medication(s):	Dosage Amount:	
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For circumstances that require immediate at		
I am requesting that the above med child/teacher as needed.* (example)		inistered by my
Please explain:		
*Note: <b>IF THE TEACHER</b> is asked to administer m	edication (they can, by law refuse).	
If the medicine EXPIRES during the school ye	ar, please select one of the following opt	ions:
Dispose of the medicine at school	Send the medication ho	ome with my child
I understand that all medications not picked	up by the end of the school year will be o	liscarded in June!
Parent Name (please print)	 Parent Signature	Date