



SHORT TERM PERMISSION – MEDICATION

CHILD'S NAME:	GRADE:
MEDICATION:	
Reason for Administering:	
Dosage:	
Dates to be given:	
Times to be given:	

I give permission for a designated member of staff to administer the above medication to my child.

Signed: _____ Contact No. _____ Date: ____/____/____
 Parent/Guardian

School Office Use Only

Date	Dosage	Time	Signature	Notes
		:		
		:		
		:		
		:		