CAPE GIRARDEAU SCHOOL DISTRICT # 63
MEDICATION PARENTAL/GUARDIAN PERMISSION FORM

Student's Name_____

Date Started_____

Expiration Date_____

I give my permission to the school nurse and/or the principle's designee to administer medication to the above named child at the time designated. Medication will be given in compliance with the recommended regulations of Administering Medicine to Students (per district policy). The district will not administer the first dose of any medication.

Name of Drug_____Time to be given_____

Dosage_____

Doctor's Name_____

Reason for Medication_____

Allergies_____

Prescription Medication_____ or Non-Prescription Medication_____

_____Oral
_____Gtube
_____Injectable
_____Drops Ear_____ Eye_____ Nose_____
_____Topical
_____Inhaler Student allowed to carry inhaler with them_____
_____Nebulizer
_____Nasal Spray
_____Rectal

Signed_____

Date_____

Contact Number:_____