# Parental Permission to Administer Medication

## Portage Township Schools

### I. Student Information/Medication Instructions:

Student's Name ______________________________ Birthdate ______________

School ______________________________ Grade ______________

Medication ______________________ Dosage ____________ Time __________

Medication ______________________ Dosage ____________ Time __________

Medication ______________________ Dosage ____________ Time __________

Reason for Medication ______________________________________________

**** I understand that I must deliver the medication personally to the school clinic if my child is below 9th grade. Students in 9-12th grades must bring medication to school clinic immediately upon arrival.**

### 2. Parent Consent:

- I request that this medication be administered at school or on fieldtrips by designated school personnel.
- I will supply prescription medication in its original, properly labeled pharmacy container.
- I will supply non-prescription medication in its original container. A physician's note is required to administer more than the label recommends.
- I will notify the school of any prescription medication changes. A physician's note or new properly labeled pharmacy container will be required to change dosages.
- I authorize the school nurse to contact my child's physician regarding questions related to medication if needed.

Parent/Guardian Signature ______________________________ Date ______________

Telephone Number ______________________________