MILLWOOD
SCHOOL

Permission to Administer Medication

I, ________________________________, give permission for my child, ________________________________, to receive his/her medication at Millwood School. This medication will be given by a member of the staff who is designated by the Head of School. The medication is in the original container.

Rx name and/or prescription # ____

Dosage to be given__________________________Time for dosage _________________

Special instructions: ____

This permission will expire after 10 days, unless signed by physician below:

Duration of medication: from ________ until ________

____________________________________ ____________________________________

Signature of parent ________________________________ Date ____________

Please note: NO MEDICATION OF ANY KIND WILL BE GIVEN WITHOUT THE CONSENT OF THE PARENT. ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER.

Signature of physician _____________________________ Date ____________