THE CapitolEncore ACADEMY

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CAPITOLENCOREACADEMY.ORG

PERMISSION TO ADMINISTER MEDICATION

This form must be filled out and signed by the doctor before medication will be administered to the student.

Student:_____ Teacher:_____ Grade:_____

I hereby request that my child be administered his/her prescribed medication by the designated school personnel. I understand that the medication will be administered per the physician's order. I will notify the school of changes or discontinuation of this medication in writing.

Beginning Date:_____ Ending Date:_____

Parent/Guardian Signature Date:

PHYSICIAN'S DIRECTIONS

To be filled out by the physician only

1. Name of Medication:_____

Dosage:_____ Frequency:_____

Time to be administered:_____

2. Name of Medication:_____

Dosage:_____ Frequency:_____

Time to be administered:_____

Physician's Signature Date:

Comments: