

PERMISSION TO
ADMINISTER MEDICATION

Date: _____

I, _____ , hereby give
(parent name)
the St. Paul Lutheran School Staff my permission
to give _____ , his/her
(student name)
medication at _____ for a period
(time[s] medicine needs to be given)
of _____ .
(number of days/weeks/months the child will be taking this medicine)

Medication

Dosage

Parent's
Signature _____