LIST ELEMENTARY SCHOOL

Mr. Jason Vislosky, Principal

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List Elementary School
Medication Permission Form

Teacher: _____

Student Name: _____ Grade: _____

Name of Medication(s) _____ _____ _____
Date to begin Date to end

_____ _____ _____
Date to begin Date to end

☐ Prescribed by a Physician or authorized prescriber
(Please provide the WRITTEN instructions on the original container from the pharmacy)

Name of Medication	Time of Administration	Dose	Route (oral/topical/nasal/inhalable/ophthalmic)

Physician's / Parent's additional instructions

Physician's signature (if required)

☐ Over the Counter
(Please provide the factory SEALED original container)

Name of Medication	Time of Administration	Dose	Route (oral/topical/nasal/inhalable/ophthalmic)

Special Instructions

Parent Signature Date

Please note medications must be brought in by an adult, not sent in with a child. Use the back of this sheet for additional instructions.