

Parent Permission for Medication/Treatment

(A separate form is required for each medication to be administered)

I request and authorize the school nurse at Dickinson High School to give the medication listed below to my child. I release school personnel from any liability should reactions result from the medication. I give my permission to the school nurse to contact my physician/dentist regarding this medication. I understand that pertinent information will be shared with appropriate school staff.

Date: _____ Child's Name: _____

Name of medication/treatment: _____

Reason: _____

Route: (circle): Oral / Inhaler / Topical

Exact date(s) to be given: _____

Exact time(s) to be given _____

Exact dose to be given: _____

Allergies: _____

Special notes: _____

Parent/Guardian
Signature _____ Date _____

Phone number where you may be reached: _____

Physician
Signature _____ Date _____

*Doctor permission is required by law for medication/treatment(s). Forms are in nurse's office or doctor may fax note on their letterhead to 302-996-1212 to the attention of the school nurse.