

VALLEY VIEW DAYSCHOOL

Medication Permission Form Prescription and Nonprescription

Child's Name _____

Name of Medication: _____

Condition for which prescribed: _____

Possible side effects: _____

INSTRUCTIONS

Dosage amount: _____ Begin Date: _____ End Date: _____

Times of day to be Administered: _____

Date: _____ Signature: _____

(Parent)

Telephone Number: _____

If Prescription:

PHARMACY: _____ PHONE: _____ Rx No. _____

Dayschool Staff: Fill in date, time and initials whenever dispensing medicine.

Monday

Tuesday

Wednesday

Thursday

Friday

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DISPOSITION OF MEDICINE: RETURNED TO PARENTS _____

Date: _____ Disposed of: _____

This form is to be placed in the child's file when medication is complete.