VARNUM PUBLIC SCHOOLS

MEDICATION PERMISSION FORM
For Medications To Be Taken At School

_____

Patient's Full Name

_____

Medication and Dosage

_____

Diagnosis

_____

Signature of Parent/Guardian

The above named student has a health condition that requires his/her taking medication during school hours.

Directions for taking medication:

Amount:_____

Time:_____

Number of Days:_____

Physician's Signature_____**Date**_____

Administration of Medication Permission and Log Sheet

Patients Name: _____

Medication and Dosage: _____

Diagnosis: _____

Parent/Guardian's Signature: _____

Directions for taking medication:

Amount: _____ __ Time: _____

Beginning Date: _____ Number of Days: _____

Physician's Signature: _____ Date: _____

Date/Time of Dosage (Signature)	Medication and Dosage	Given By

CAUTION! Positively identify this student and be certain that the correct medication and dosage is administered.