Apple Tree Connections Medication Permission Slip

Date: _____ Classroom: _____

Child's Name: _____ Parent's Name: _____

Medication Name: _____

Last time this medication was given by parent or other: _____

Times to be given: Dose 1_____ Dose 2_____ Dose 3 _____

Dosage: _____

Parent's Signature: _____

Note: This request form must be signed DAILY for each medication. No medication will be given without a parent's signature and a current prescription label for that child or proper age and weight requirements for "over the counter" medications. Over the counter medications may require physician's orders prior to administering.

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