Student Medication Permission and Instruction

I give permission to the Outlook Christian School Staff to give or apply

_____ to my child, _____, as follows:

(Specify prescribed medication/over the counter product)

(Child's Name)

Directions:

Date to Begin Giving Medication:	Date to Stop Medication:
Times Medication is to be Given:	Amount (dosage) of Medication Each Time Given:

Other Directions (please check all that apply):

- Contact parent before administering this medication

  Contact Number: _____

Other instructions:
(ex: My child can have this medication, Tylenol, no more than once a day & only for headaches)

Note: All medication must be in its original packaging and must be stored by staff in a locked location.

Signature of Parent:	Date:

To be completed by Outlook Christian School Staff:

Date	Time	Amount Given	Staff Name	Staff Signature

To be completed by Outlook Christian School Staff:

Date	Time	Amount Given	Staff Name	Staff Signature