Trinity Junior High

Parent Permission for Administering Medication

I give the school permission to administer the following medication to my child,

Name: _____ Grade: _____

Name of Medication	Dosage	Time to Administer	Physician

I am to notify the office immediately if there is a change in the above medication(s)

_____ _____

Parent Signature Date

This is to be completed for both prescription and over-the-counter medication.