Permission to Give Medication

I, _____, give my permission for my child,
_____, to receive his/her medication at
St. Michael's Episcopal School. This medication will be administered by a member of the staff
who is designated by the Head of School. The medication is in the original container.

Drug name and/or prescription number: _____
Dosage to be given: _____
Times to be given: _____
Special instructions (if any):
_____
_____

This permission will expire after 10 days. Please renew authorization after that time if necessary.

_____ _____
Signature of Parent Date

NO MEDICATION OF ANY KIND WILL BE GIVEN WITHOUT THE WRITTEN CONSENT OF THE PARENT.
ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER.

For those students who will be taking medication on a regular basis throughout the school year, please provide written authorization from the child's physician. Forms are available from the office. Please check with the school periodically to make sure there is enough medication on hand.

Thank you for your cooperation.

St. Michael's Episcopal School
8706 Quaker Lane
Richmond, VA 23235
272-3514 • fax 323-3280