St. Ansgar Community Schools

K-12
206 East 8th Street
St. Ansgar, IA 50472

MEDICATION PERMISSION FORM

STUDENT'S NAME: _____GRADE:_____

MEDICATION: _____

DATE TO BEGIN:_____DATE TO END:_____

DOSAGE: _____

ROUTE: oral, eye drops, nose drops, inhaler, injection, other_____

AMOUNT TO BE GIVEN: _____

TIME TO BE GIVEN: _____

ILLNESS OR CONDITION REQUIRING MEDICATION:

_____
_____
_____

Medication shall be administered when the student's parent or guardian (hereafter "parent") provides a signed and dated written statement requesting medication administration and the medication is in the original labeled container, either as dispensed or in the manufacturer's container.

PARENT SIGNATURE: _____DATE: _____