

**VISITATION INTER-PARISH SCHOOL
2010-2011
MEDICATION AT SCHOOL PERMISSION SLIP**

Student's Name: _____

Parent's Emergency Phone #: _____

Name of Medication: _____

Dosage: _____ Time(s): _____

Condition treated by the medication: _____

Date(s) to be administered: _____

Does this medication need refrigeration? Yes No

Does this medication need to be sent home daily? Yes No

Any adverse reaction that may be caused by the medication:

All medications must come to school in the original container or with a copy of the label with child's name on the container. No medication will be dispensed without this form!

PARENTS/GUARDIANS: Your signature indicates the accuracy of the above information, knowledge of possible side effects, and your understanding of the school's policy for administering medications.

Please **PRINT** parent/guardian's name: _____

I hereby grant permission for school personnel to administer the above medication to my child as instructed above. I do not hold school personnel liable for administering the above named medication if my child develops any type of medical symptoms.

Parent/Guardian Signature

Date