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:

____
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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: ________