



# MEDICAL PERMISSION FORM

Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Class: \_\_\_\_\_

I \_\_\_\_\_ give permission for a school staff member  
(PARENT/GUARDIAN'S NAME)

To administer \_\_\_\_\_  
(NAME OF MEDICATION AND QUANTITY)

To the above named Student at \_\_\_\_\_ on \_\_\_\_\_  
(TIME/S) (DAY/S DATE)

Signed: \_\_\_\_\_