MEDICATION PERMISSION FORM

To be completed by physician:

Student's Name _____ Grade _____ Age _____

Name of Medicine _____ Dosage _____

Reason _____ Times _____

Termination Date _____

Possible Side Effects/Contraindications _____

_____

Student Restrictions _____

Physician's Signature _____

Physician's Phone Number _____ Date _____

Prescribed medication must be in original labeled bottle. Send only the amount needed.

To be completed by parent:

I will take full responsibility for the prescribed medication, which is to be taken by my son/daughter during the hours my child is at Ability Tree.

I relieve Ability Tree and its employees of any responsibility for the benefits or the consequences of the medication.

Parent/Guardian Signature _____ Date _____

Home Phone Number _____ Work Number _____

Ability
LEARNING CENTER