Permission to Administer Medication
Iola ISD

Student Name: _____

Date of Birth: _____

Grade: _____

Home Phone Number: _____

Parent/Guardian Name: _____

Day Phone Number: _____

Name of medication: _____

Dosage: _____

How to Administer: _____

Reason for taking medication: _____

Comments: _____

Doctor's Name & Phone Number: _____

Today's Date; _____

Parent/Guardian Signature: _____

List any medication allergies: _____

ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER TO BE DISPENSED AT SCHOOL!!