Hartford High School Health Services Office

Non-Prescription Medication Permission Form

Student Name: _____ Date of Birth: _____ Grade: _____

Medication: _____

Dosage/Route/Time: _____

Start Date: _____ End Date: _____

Reason for Giving: _____

I hereby give permission for the above named student to receive the medication as described above while at school.

Signature of Parent/Guardian: _____ Date: _____

Note: Medication must be supplied to the school Health Office in its original container and will only be given according to the manufacturer's instructions. Medications may be administered by the school nurse or an adult delegated to by the nurse.

Date Received: _____ Signature of School Nurse: _____