SPARTA TOWNSHIP PUBLIC SCHOOLS
MEDICATION PERMISSION FORM

NAME ____________________ DATE __________________

SCHOOL __________________ GRADE ___________

DIAGNOSIS _______________________

MEDICATION _____________________ DOSAGE ___________ TIME______

DURATION: FROM ________________ TO________________________

ADVERSE REACTIONS ____

PARENT/GUARDIAN SIGNATURE ____________________ DATE ________

PHYSICIAN SIGNATURE ____________________________ DATE________

MEDICATION MUST BE IN THE ORIGINAL CONTAINER, APPROPRIATELY LABELED AS DISPENSED BY THE PHARMACIST OR HEALTHCARE PROVIDER. MEDICATION MUST BE BROUGHT IN BY A PARENT/GUARDIAN OR ADULT. MEDICATION WILL NOT BE ACCEPTED FROM A MINOR STUDENT.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															

INITIAL	NAME
______	______________________
______	______________________
______	______________________
______	______________________
______	______________________

CODES

/-WEEKEND H-HOLIDAY F-FIELD TRIP

AB-ABSENT N-NONE AVAILABLE

O -NO SHOW W-DOSE WITHHELD

D-EARLY DISMISSAL