PROVISO
MATHEMATICS AND
SCIENCE ACADEMY
"A CATALYST FOR GREATNESS"

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MEDICATION PERMIT

_____ _____ ____/____/____
Name of Student **ID#** **Birthdate**

The above named pupil has_____
(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication during school hours.

_____ Type of Medication: Tablet, Liquid, or Capsule
Name of Medication **(Please Circle)**

_____ _____
Dosage **Time(s) to be given**

_____
Possible Side Affects

I certify that _____ has been instructed in the use and
(Name of Student)

self-administration of _____
(Name of Medication)

I hereby authorize my child to self-administer, while under the supervision of the employees and agents of the School District, lawfully prescribed medication in manner described above.

He/she understands the need for the medication, and necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone number in the event of a reaction or an emergency:

_____ ____/____/____ (____)_____-_____
Signature of Parent Date Daytime Phone

_____ (____)_____-_____
Name of Emergency Contact Daytime Phone