Sparta Township School District

Medication Permission Form

Student's Name: _____ Date of Birth: _____

School: SHS SMS HMS MAS AES

School Year: _____ Grade: _____

Parent/Guardian 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.

Physician/Nurse Practitioner To Complete This Section

Order Date: _____

Diagnosis/Reason for Medication: _____

Medication: _____ Strength: _____ Dosage: _____

Time:_____ Route: _____ Duration: From _____ To _____

Adverse Reactions: _____

If medicine is to be given "As Needed", describe indications: _____

_____

Print Physician's Name:_____ Phone: _____

Address: _____ City/State/Zip: _____

Physician's Signature: _____ Date:_____

Physicians Stamp

Reviewed and verified by School Nurse: _____ Date: _____