BURLINGTON SCHOOL DISTRICT
PERMISSION FOR MEDICATION

______________________________ ____________________ __________
Name of Student School Grade

Medication:

Dosage:

Directions:

Reasons for Giving:

____
Signature of Physician

____
Name of Physician (please print)

____
Telephone Number

I hereby give my permission for student____________________________________ to take the above prescription (medication) at school as ordered.

____
Signature of Parent or Guardian

____
Date

No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled.

Non-prescription medication does not require a physician's signature unless it is for ongoing long term use.