Permission to Administer Medications

Princeton Day School

Parent or guardian and ***physician signature*** *required*

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Student Name   Date of Birth

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Parent Name

Current medications child takes including drug name, dosage, route, time(s) of day and if taken with food.
Are these medication(s) to be administered at school? ☐ **Yes** ☐ **No**

Medication 1: ______________________________ Taken with food? ☐ **Yes** ☐ **No**

Dosage: __________ Route: ____________ Time of Administration: ______________

Medication 2: ______________________________ Taken with food? ☐ **Yes** ☐ **No**

Dosage: __________ Route: ____________ Time of Administration: ______________

Medication 3 ______________________________ Taken with food? ☐ **Yes** ☐ **No**

Dosage: __________ Route: ____________ Time of Administration: ______________

If **yes**, I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted.

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Parent/Guardian Signature   Date

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Physician Signature   Date