

**RAINBOW PEDIATRICS
44 COLLINS DRIVE
SUITE 202
MIDDLEBURY, VT 05753
802-388-1338
FAX: 802-388-8244**

MEDICATION PERMISSION FORM

Student: _____ Grade: _____

School: _____

Medication: _____

Directions: _____

Reason for giving: _____

Date

Doctors Signature *

I hereby give permission for my child to take this medication at school as ordered above.

Date

Parent/Guardian Signature **

* Physician's signature and parental permission are required for PRESCRIPTION medications (doctor ordered medications).

** Parent/Guardian's signature only is required for NON-PRESCRIPTION ("over-the-counter") medications, but please complete this form as specifically as possible.

No medication will be given at school until the school nurse/school receives this completed form.

Medication should be brought to school in a container appropriately labeled by the pharmacy or physicians.

Medication shall be kept in the Health Room Office during school hours.