WOODRUFF HIGH SCHOOL

Prescription Medication Form

I give permission for the following medication to be given:

Student's Name_____

Name of Medication_____

Prescribing Physician_____

Dosage to be Given_____

Time to be Given A.M._____

P.M._____

Special Instructions _____

_____

_____

_____ _____

Date Parent Signature

Phone Numbers: Home_____ Work_____

Cell_____ Emergency_____