

Kimball School District #7-2

Dispensing Medication Form

I hereby authorize medication _____
(Name & Prescription Number)

For my child _____ to be administered at the Kimball School

Reason child is taking medication: _____

Procedure for dispensing medication (i.e. when administered, etc.):

TIME _____

DOSAGE _____

DURATION _____

ROUTE: _____

Doctor: _____

Parent/Guardian Signature

Date

Verbal Permission received by:

Date: