# Medicine Distribution Permission Form

Student Name:_____

Student DOB: _____

Parent/Guardian Name:_____

Parent Phone number:_____

Please fill out the table below with Medicine name, dosage to be given, any instructions, and circle all times of day that apply. Please send this form with medicine in the original prescription bottle with the students name on it. Over the counter meds need to be in the bottle/package. Please put all medicine bottles in a ziploc bag labeled with your students name.

| **Medicine Name** | **Dosage Given** | **Time to give** | **Instructions** |
|---|---|---|---|
| | | AM Lunch PM | |
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| | | AM Lunch PM | |

I,_____, give the directors/staff of the Springtown High School Band permission to administer medicine, prescription and/or over the counter, to my son/daughter. I also understand that it is my student's responsibility to find the director(s) at the appropriate time to receive their medicine.

Parent Signature:_____
Student Signature:_____