NASD

Parental Consent Form for Antibiotics or Short-Term Medications Used 10 Days or Less

_______________________________________ at _______________________
Student's Name   School

Has my permission to take the medication listed below. The medication was prescribed by Dr.______________________ for the purpose of ________________________.

I give my permission for the school nurse to contact the physician/dentist if necessary.

Name of Medication: ____

Dosage to be Given: ____

Time to be Given: ____

Beginning Date: ______________________ Ending Date: ____________________

Signature of Parent/Guardian:____

Date Signed: ____