MEDICAL PERMISSION SLIP 2021/2022

I authorize the office personnel of Country Elementary School, Pinckney, Michigan to administer medication to my child, _____

Name of Medication: _____

Dosage to be Given and How often: _____

Time Medication Should be given: _____

Any other information you feel would be helpful: _____

_____

Date: _____ Parent or Guardian Signature_____

Medication Picked Up:_____

(Signature/date)

****

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****

Student's Teacher:_____ Grade:_____