Codman Academy Charter Public School, 637 Washington Street, Dorchester, MA 02124, 617-287-0700

PRESCRIPTION MEDICATION ADMINISTRATION CONSENT FORM

NAME OF STUDENT: _____ GRADE: _____

NAME OF MEDICATION:_____

DOSAGE (amount to be giving at school):_____

REASON FOR MEDICATION:_____

TIME (to be taken at school):_____

DATE BEGINNING MEDICATION: _____ DATE ENDING _____

I am the parent/guardian of _____. I give my permission and request that designated school personnel administer the above medication at the times and date indicated above. I agree to furnish prescription medication in the original container with the label intact.

_____ _____
Doctor's Signature Date

_____ _____
Parent/Guardian Signature Date