Date	Med Count	Nurse Sign	Parent Sign

Date	Height	Weight	BP	Heart Rate

Date: _____

I give my permission to the school nurse or other authorized employee to give the following medication to my child. All medications will be given in accordance with GISD policies FFAC (legal) and FFAC (local).

_____

Student Name

_____

Name of Medication

_____

Dose to be given

_____ _____

Time(s) Prescribing HCP

X _____

Parent/Guardian Signature

___Take home daily ___Leave at school
___Student to transport medication
___Parent will pick up medication
___Medicine brought by student w/note
___Medicine brought by student w/o note

Added information and notes: