Perry Township Schools

Authorization to Carry Medication

Student name: _____

Date of birth: _____Grade:_____ Homeroom teacher:_____

Address:_____

Parent phone numbers: H/W/C_____

Medication Name:_____

Dose: _____Time (or frequency if PRN):_____

Special Instructions:

_____

_____

My child has permission to carry and administer the above stated medication during school and/or school related activities.

_____/_____
Parent/Guardian Signature Date

_____/_____
Physician/Healthcare Provider Signature Date