



Student Name: _____ Grade: ____ Teacher _____

MEDICATIONS TO BE DISPENSED AT SCHOOL SHOULD BE KEPT TO A MINIMUM.

_____ is being treated under my supervision and needs the following medication(s) to be taken at school at the following times of the school day.

Start Date	Medication	Dosage	Time	End Date

I consent to allow Oakhill Day School personnel to dispense medication to my child as provided in the above written guidelines.

I consent to allow my child to transport any medication to and from school and home.

(Date)

(Signature of Parent/Guardian)