Dryden Central School District

Permission to Administer Medication at School

Name of Student: _____ DOB: _____

Name of Medication: _____

Dose: _____ Route: _____

Time: _____

I, the parent or guardian for _____, authorize Dryden

Please print name of student

Central School District to administer the above medication to my child during the school

year _____.

Please specify school year (e.g.2018-2019)

_____ Date:_____

Signature of parent/guardian

_____

Print name of parent/guardian