

# Medication Permission Agreement

Child Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

## Over-the-Counter Medications

My child has permission to take over-the-counter medications administered by The Veritas School personnel.

Notes/Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Prescription Medications

My child is on prescription medication: Yes No

If yes, please list: \_\_\_\_\_

Notes/Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_