Eleanor Kolitz
HEBREW LANGUAGE ACADEMY
אלינור קוליץ האקדמיה לשפה העברית

Parental Consent for Administering Medication for 10 days or less

Name of School______________________________________ School Year______________

Student's Name____ DOB_______________

Grade _______ Home room Teacher____

Allergies ____

Parental Consent

I am the parent or guardian of ____.

I give my permission for him/her to take the following medication while in school, according to school policy:

Name of medication: ____

Amount to be given: _________________________ Time to be given ___________________

Start date:____________________________ Stop date:____________________________

Reason medication being given: ____

Printed name of parent/guardian ____

Signature of parent/guardian ______________________________________ Date __________

Home telephone: ________________________ Work/cell phone: ________________________

Amount of medication received ____

08/01/2013