MEDICATIONS PERMISSION FORM

E. H. MOTT LEARNING CENTER

LEARNER NAME:	D.O.B.	GRADE:

By signing this form, I give my permission for any E. H. Mott Learning Center staff member to administer the following medications or medical treatments to my learner when deemed necessary. The staff member will record the name of the medication, date, time, and the amount given. This form will be kept on file. Medications will be administered according to pre-stated parental directions or according to medication label. We cannot be responsible for medications that the learner takes without the knowledge of the teacher or designated staff member or that is self-administered.

Please initial all medications that you will approve in the boxes provided:

First aid for cuts, skin irritations, insect bites and stings:

☐ Alcohol solutions ☐ Antibiotic ointment ☐ Ibuprofen (Advil or Motrin)

First aid for minor pain, headaches or allergies:

☐ Benadryl ointment ☐ Benadryl ☐ Acetaminophen (Tylenol)

☐ Other____________________________________

Medications that my learner takes daily or on a regular basis (inhalers, insulin, etc.):

Name of medication: _________________________ Dosage: __________________

Time Taken: _________________ Reason for medication: _____________________

Allergies to medications: ____

Serious Conditions or Illnesses: ____

Please sign below if the above first aid measures and medications indicated are acceptable. You are giving permission for our staff to administer these medications.

Signature of Parent/Guardian/Legal Representative	**Date**