



DEPARTMENT OF DEFENSE  
OFFICE OF DEPENDENTS EDUCATION  
4040 NORTH FAIRFAX DRIVE  
ARLINGTON, VA 22203-1634

DS Regulation  
Enclosure 2

### PERMISSION FOR MEDICATION

Name of Student: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Parent Phone Number: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Physician Phone Number: \_\_\_\_\_  
Medication and Dosage: \_\_\_\_\_  
Duration of treatment: \_\_\_\_\_  
Time of day medication is to be given: \_\_\_\_\_  
Other medications taken: \_\_\_\_\_  
Possible side effects: \_\_\_\_\_  
Anticipated number of days to be given at school \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's signature

I hereby give my permission for School Officials to administer the above prescribed medication to my child. I understand it is my responsibility to furnish this medication.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's signature

***NOTE: The prescription medication must be brought to school in its original container, appropriately labeled by the pharmacy or physician, stating the name of the child, the medication and the dosage, and the date issued. The medication will remain at the school for the duration of the prescription.***