Dr. Eric Jackman Institute of Child Study
UNIVERSITY OF TORONTO

Each time your child requires medication to be administered at school please complete this permission form. You may retain this copy for future use. Additional copies are available in the School Office.

Permission to Administer Medication

Please indicate whether this medication is prescription or non-prescription:

☐ Prescription Medication

☐ Non-Prescription Medication

I hereby give my permission to the staff (Principals, Teachers, and School Office Staff) of the Dr. Eric Jackman Institute of Child Study to administer:

_____ _____

Name of Medication *Prescription Number, if applicable*

_____ _____

Dosage *Schedule for Administering* *(include date range, if applicable)*

to my child, _____ in Grade ___ according to the medical physician's instructions printed on the prescription container (for Prescription Medication) or according to the medical physician/parent's instructions (attach or provide instructions below).

Instructions:

_____ _____

Signature of Parent/Guardian *Date*

☐ Check here if permission is ongoing for academic year 2024/2025 and can be administered on any day.

For Office Use Only (attach log, if medication is administered for multiple days)

Staff Name: _____ Date: _____ Time: _____

Name of Medication: _____ Quantity: _____ Signature: _____
Observations/Notes:

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