



Medication and Dental Permission Form
Landmark High School
 Academic Year 2012-2013



Student's full name: _____ **Birth Date:** ____/____/____

PERMISSION TO ADMINISTER MEDICATIONS

Do you authorize Landmark to administer medication to the student named above? This includes prescription and over-the-counter medication, like Tylenol, cough syrup, Epi-Pen, etc...

Yes **No**

DENTAL EMERGENCY PERMISSION

Do you authorize Landmark to obtain dental care for the student named above, if dental emergencies occur or if emergency orthodontic treatment is necessary?

Yes **No**

CURRENT MEDICATION INFORMATION

Include information about any medication student is currently taking. Please use a second print-put as needed.

Name of Medication:	Dosage:	Time to be given:	<input type="checkbox"/> I will continue to purchase and send this medication. <input type="checkbox"/> I wish Landmark to purchase this medication and charge my child's student bank account.
Prescribing Dr. name & address:			
Name of Medication:	Dosage:	Time to be given:	<input type="checkbox"/> I will continue to purchase and send this medication. <input type="checkbox"/> I wish Landmark to purchase this medication and charge my child's student bank account.
Prescribing Dr. name & address: (<input type="checkbox"/> same as above)			
Name of Medication:	Dosage:	Time to be given:	<input type="checkbox"/> I will continue to purchase and send this medication. <input type="checkbox"/> I wish Landmark to purchase this medication and charge my child's student bank account.
Prescribing Dr. name & address: (<input type="checkbox"/> same as above)			

PARENT/GUARDIAN SIGNATURE

Print name:	Signature:	Date: / /
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