Florence School District 5 Health Services

"Healthy Flashes Learn Better"

Parent Permission for Administration of **OTC** Medications at School

Date: _____ School Year: _____

To Whom It May Concern:

I, _____, give permission for the licensed nurses and/or trained unlicensed assistive personnel (UAP) of Florence School District Five to administer _____ to my child, _____, for the following reasons:

_____

_____.

Parent Signature: _____ Date: _____

RN Signature: _____ Date: _____

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