Forschool year				
PERMISSION TO AD	MINISTER	MEDICATION	AT SCHO	OL
KELLOGG MIDDLE SCHOOL Shoreline School District 16045 25 TH AVE. N.E. Shoreline, WA 98155		ATTENTION: FAX: PHONE:	206.393.4° 206.393.4°	780
Student	Birth date		Grade	Age
Parent	Address			Phone
Parent Licensed health professional		Phone		Fax
This section to be completed by PAREN				
				cation in the original container,
and for immediately notifying the school nurse (or principal)	of any change in of any change in the definition of the definition	n these instr	uctions.
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the instructions indicated above from [dates]

* Signature of Licensed Health Professional

I request and authorize that the above-named student be administered the above-identified medication as per

as there exists a valid health reason which makes administration of the medication advisable during school hours.

Name [PRINT OR TYPE]

to _____ [not to exceed current school year]

Date