BOARD OF EDUCATION
FULTON CITY SCHOOL DISTRICT
FULTON EDUCATION CENTER
167 SOUTH FOURTH ST
FULTON, NEW YORK 13069

MEDICATION PERMISSION

Student Name _____ School Year _____

Medication _____ _____ _____

_____ _____ _____

I give the School Nurse permission to administer medication to my child for this school year.

Parent Name (please print) _____

Parent Name (please sign) _____

Date _____

Doctor's Orders Received _____

Medication Received

Date	Medication Name	Amount	Initial