Eudora School District USD 491
Health Services

Authorization for Nonprescription Medication-Confidential

Name of Student _____ Date of Birth _____

School _____ Grade_____ Teacher _____

Medication _____ Dose _____

Reason for Medication _____

Time of day medication is to be Given _____ Side Effects_____

Special Instructions _____

Has the first dose of this medication been given? YES NO
****District Policy does not allow school personnel to give the first dose of medication****

I hereby release the school district and personnel from any liability for damages as a result of an adverse reaction to this medication, and acknowledge that the school bears no responsibility for ensuring the medication is administered. I authorize the disclosure of information regarding this

medication from _____ to USD 491 and from
Name of Provider

the records of USD 491 to _____. I understand
Name of Provider

that the information thus obtained will be treated confidentially.

Date _____ Signature of Parent/Guardian _____

NOTE: If the medication is needed for more than 10 doses, a prescription will be required in order for the medication to continue to be given at school. The medication must be provided in its original packaging with a legible label and authorized for the dosage recommended for children on the package.

Date/Time/Initials Date/Time/Initials Date/Time/Initials Date/Time/Initials Date/Time/Initials

Date/Time/Initials Date/Time/Initials Date/Time/Initials Date/Time/Initials Date/Time/Initials

_____ Parent/Guardian _____
Healthcare Personnel Signature

Date _____