



PARENT'S NON-PRESCRIPTION MEDICATION ADMINISTRATION REQUEST FORM

Child's Name _____ Birth Date _____ Grade _____

Child's Address _____

Medication _____

Medication is used for _____

Dosage or Procedure Required _____

Time Required _____

Possible adverse reactions, which should be reported to the parent

Special instructions for administration _____

Date when administration of medication or procedure is to begin _____

Date when administration of medication or procedure is to end _____

As a parent or legal guardian of the above-named child, my signature below authorizes school personnel to administer the medication as instructed by the parent. I understand that a trained staff member administering the medication might not be a health professional.

1. I will deliver the medication to the clinic staff in its original container. Student may not transport.
2. I will notify the clinic staff immediately if there is any change in the use of this medication or the prescribed treatment.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for the damages or injury resulting directly or indirectly from this authorization.
4. I agree that this form is in effect for the duration of the current school year unless stated below.
5. The school will not treat/medicate for a fever or diarrhea.
6. Medication given more than 3 days in a row, 3 days in a month or 10 doses per school year will need a Physician medication order.
7. Medications that can be given at home, such as once or twice daily medications, should be given before and/or after school.
8. If this medication is given at home, the guardian will call the school clinic to let them know what time it was administered.

I have read and agree to the above statements:

Parents Signature: _____ Date: _____

