Medication Request Form for Non-Prescription Medication

Name of Student____ Grade________ D.O.B___/___/___

Medication Name____

Reason for medication____

Directions for use____

For Parents/Guardians:

By singing below I agree that I am primarily responsible for administering medication to my child. However, in the event I am unable to do so or in the event of a medical emergency, I hereby authorize the school district and its employees and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school district), over-the counter or non-prescription medications in the manner described above. I acknowledge that it may be necessary for the administration for the medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication**. I also understand that any non-prescription medication to be taken at school must be sent in the original container with the students name on it.**

Parent/Guardian ____(print)

____(sign)

____________________(date)

This form will be kept on record for the school year. Any medications left at the end of the school year will be attempted to be returned or discarded. No medications that are expired will be administered to the student. Thank you.