



Haslett Public Schools
Authorization for Administration of
Non-Prescription Medication
Ralya Elementary School
517-339-8202
517-339-7359 (fax)

Date form was received at school _____

Name of Student: _____

Birth Date: _____ Grade: _____ Teacher: _____

To be completed by the parent/guardian:

Name of medication: _____

Instructions (Schedule and dosage to be given at school): _____

Reason for medication: (Optional) _____

Form of medicine/treatment:

Tablets/capsules Liquid Inhaler Other

Additional dosage permitted in emergencies only by telephone call with parent.

Restrictions and/or pertinent effects: None anticipated.

Yes, please describe: _____

Special storage requirements: None Refrigeration Other

Start Date if not the beginning of school: _____

Stop date if not end of the school year: _____

I request that _____ receive the above medication at school according to standard school policy. (Name of student.)

Parent/Guardian Signature

Date

Relationship

Physicians Name: _____ Phone # _____

Address: _____
