

Ashland City School District
P.O. Box 160 1407 Claremont Ave. Ashland, Ohio 44805 Phone (419) 289 - 1117

Non- Prescription Medication

The following information is necessary for a student to be administered a non-prescribed medication. The Non-Prescriptive Medications will follow the same state guidelines as Prescriptive Medications.

***Non-prescriptive Medication MUST*:**

- Be accompanied with the Ashland City School District's Preschool Non-Prescription Medication Form;
- Be brought to the school by the parent/guardian;
- Be in its original container and identify the appropriate dosage for the student;
- Be delivered to the designated school personnel; and Be administered by designated school personnel.

[1]***If this completed form is <u>NOT</u> provided or the non-prescribed medication is <u>NOT</u> in its original container the school staff will not administer the medication. Students may <u>NOT</u> possess Non-Prescription medications on their persons - for example: book-bag, pocket or locker. ONLY ONE NON-PRESCRIPTIVEMEDICATION MAY BE LISTED PER MEDICATION FORM.***

[2]***If there is any change in medication, dose, or instructions, a new form must be completed.***

Student Information

Date: _____

Student Name: _____ **Age:** _____
Last *First* *MI*

Address: _____ **Zip Code:** _____

Phone Number: _____ **Emergency Number:** _____

Medication Information:

Name of Medication: _____ **Expiration Date:** _____

Amount/ Dosage to be Taken: _____

Time Non-Prescribed Medication is to be taken: _____

Route: _____ **Reason for Use of Medication:** _____

Possible Side Effects/Reactions which, if they occur, should be reported to the parent: _____

_____

Administration to Begin: _____ **Administration to End:** _____

Parent/Guardian Information

I, the Parent/Guardian of the named student:

- Will assume responsibility for safe delivery of the listed non-prescribed/over the counter medication to the school. I understand the medicine must be brought to school in its original container and will be kept in a secured medical location.
- Will notify the school immediately if there is any change or cancellation in the use of non-prescriptive/ over the counter medication.
- Understand the qualified designated person(s) will be administering the medication.

Guardian Signature: _____ **Date:** _____

Guardian Name (printed): _____