ADMINISTERING NON-PRESCRIPTION MEDICATIONS TO STUDENTS

Parent's Statement for **OVER-THE-COUNTER** Medications

Student's Name _____

Grade _____ Teacher _____

Address _____ Phone _____

Name of the medication(s) to be given _____

Dosage of the medication _____ every _____ hours as needed.

Brief description of student's condition _____

Any Special Instructions _____

_____

I request that my child receive the above medication as needed at school. The medication is to be furnished by me as required by school board policy. I understand that the district is rendering a service and does not assume any responsibility for this matter. I further understand that the school nurse or other designated persons will administer the medication. **THE MEDICATION MUST BE SENT IN THE ORIGINAL PILL BOTTLE OR PACKAGING.** All medications must be picked up by the last day of the school year. Unused medication will not be sent home with students. Medications left at school after the last day of school may be disposed of properly.

Signature (Parent /Guardian) _____ Date _____

Parent/Guardian name (please print) _____