School District of Washburn
Non - Prescription Medication Authorization Form
Note: each medication requires a separate form

Medication must be in original container*

Parent completes this section:

Students Name: _____ Address: _____

School: _____ Grade: _____ Teacher: _____ Birthdate: _____

Physician's Name: _____ Clinic: _____ Phone: _____

Medication Name	Dose	Time Given	Reason
1)			
2)			
3)			

Any specific instructions:

If medication is given "as needed" describe indications:

How soon can medicine be repeated:

I hereby give permission to school employees designated by school officials to give medication to my child according to my direction.

I further give permission to school authorities to contact my child's physician regarding this medication.

I further agree to notify the school in writing at the termination of this request or when any medication changes occur.

I further agree to hold the School District of Washburn and all employees harmless in any and all claims arising from the administration of this medication.

Parent's Signature	**Date:**
Phone No.	**Work or Cell Phone**

A doctor's written order and the doctor's signature are required for school staff to administer *any dose other than the recommended dose that is indicated on the label.*

Name of Medication:	Dose:	Time Given:

Physician's Signature:	**Date:**
Clinic:	**Phone:** **Fax:**