SIDNEY CITY SCHOOLS

750 S. FOURTH AVENUE
SIDNEY, OHIO 45365
MAIN: 937-497-2200
FAX: 937-497-2211

PARENT/GUARDIAN REQUEST FOR NON-PRESCRIBED MEDICATION BY SCHOOL PERSONNEL

Student's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Parent/Guardian's Name: _____ Phone: _____

I hereby request and give my permission to the principal or a designee (nurse, secretary, teacher, or other responsible trained person) to administer the following medication to my child:

Name of Drug: _____ Dose: _____Times:_____

Reason for the drug to be administered at school: _____

Beginning date of request:_____ Expiration date of request: _____

Name of Drug: _____ Dose: _____Times:_____

Reason for the drug to be administered at school: _____

Beginning date of request:_____ Expiration date of request: _____

_____
Parent/Guardian Signature Date

Parents MUST bring medication to school in its original container and deliver it directly to the office.

Note: The parent/guardian of the child must assume responsibility for informing the principal or a designee (nurse, secretary, teacher, or other responsible trained person) of any change in the child's health or any change in the non-prescribed medication. Any change to the above non-prescribed prescription (dosage or administration) will require the completion of a new form.

_____
School Official's Signature (Acknowledging Receipt) Date

Revised 11/24;6/25 Office Use Only - Homeroom/Grade _____