Permission for School Administration of Non-Prescription Medication

School District: Richland School District One

School Year _____

For school use only:
- ☐ Routine
- ☐ PRN (As needed)

Start Date: _____

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter, medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school. I understand that with the signing of this Non-Prescription Medication Form, Neither the school district nor its personnel will be responsible for the occurrence of any adverse drug reaction when the medication has been given in the manner prescribed.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

_____ _____
Child's Name Date of Birth

_____ _____
Name of School Grade

Is your child allergic to any food, medicines, or other items? ☐ No ☐ Yes (If yes, list allergies.)

Name of medication to be given at school:	
Reason for medication:	
Amount of medication to be given:	Time of day medication to be given at school:
Note any special storage requirements: ☐ Refrigerate ☐ Other (please specify)	Estimated number of days medication will be given at school (choose one): ☐ _____ days ☐ _____ weeks ☐ until the end of the current school year ☐ until the end of Summer School for the current school year
Does your child take any other medications at home or at school? ☐ No ☐ Yes (If yes, what are the medications?)	

Child's Health Care Provider's Name and Address (please print):	Office Phone Number:
	Office Fax Number:

I give permission for the medication noted above to be given to my child during the school day. I give permission to the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission to the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I give permission for the trained Unlicensed Assistive Personnel (UAP) to assist my child with medication when the school nurse is unavailable. I understand that I am responsible for notifying the school if any of my child's medications change and/or changes to my contact information.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print or Type Name of Parent / Guardian Day Phone Number

Update 11.2025