



School Health Services
Non-Prescription Medication Administration at School

Attach Student Picture If available

School:
School Year:
Class/Grade:

Student Name: Date of Birth:

Student Address:

Name of Medication: Dose:

Time to be given (during school hours):

Reason for Medication to be administered:

Form of Medication: Tablet Liquid Other

Start date: Stop date:

Special Instructions:

Potential adverse reactions to be reported to parent or physician:

Physician/Healthcare Provider Name: Phone:

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy. I agree and am responsible to:

- Medication to be delivered to school by parent/guardian, not expired and in its original container.
Tell the school as soon as possible if there is a change in the use of this medicine.
Complete a new medicine form for this medicine if there are dose changes.
If this medication is needed for greater than 4 consecutive days a healthcare provider order is required.

I agree for child's healthcare provider to talk with the school or any school staff person about this medication if needed. No other part of my child's medical health will be discussed. When my child receives this medication I will be notified.

Parent/Guardian Signature: Date:

Parent/Guardian Phone: Emergency Alternate Phone:

\*\*THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR\*\*\*