

Parent/Guardian Request for Administration of a NON-PRESCRIPTION MEDICATION

Dispensing FDA approved over-the-counter medications at school requires:

- 1) Written authorization from parent/guardian
- 2) The medication supplied in original container by parent/guardian

**If more than 10 doses of medication to be given throughout school year,
physician/licensed prescriber authorization must be obtained.**

Student Name: _____ **Grade:** _____ **Teacher:** _____ **Birth date:** _____

I authorize designated school personnel to dispense to my child the following medication(s). I release school personnel from liability in the event any reaction results from the medication(s).

Medication Name: _____ **Dose:** _____ **Frequency:** _____

For treatment of: _____ Special Instructions: _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

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For treatment of: _____ Special Instructions: _____

If necessary, school personnel may request additional information from the prescriber regarding this medication.

Parent/Guardian Signature: _____ **Date:** _____

Day time Phone: _____

I authorize my child to bring this medication home at the end of the school year.

Kennedy 1175 Tyler (651) 480-7224 fax: (651) 438-0048	McAuliffe 1601 W. 12 th (651) 480-7395 fax: (651) 480-7392	Middle School 1000 11 th St. W (651) 480-7072 fax: (651) 480-7064	Pinecrest 975 W. 12 th (651) 480-7286 fax: (651) 480-7282	Senior High 200 General Sieben (651) 480-7486 fax: (651) 480-7490
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Date returned to Health Office _____ Entered on computer _____ Staff signature _____ Med available _____