

USD #257
REQUEST FOR NON-PRESCRIPTION (Over-the-Counter) MEDICATION
ADMINISTERED
DURING SCHOOL HOURS

NAME OF STUDENT _____

SCHOOL _____ **GRADE** _____

MEDICATION _____ **DOSAGE** _____

REASON FOR MEDICATION _____

HOW OFTEN SHOULD MEDICATION BE GIVEN? BE SPECIFIC. (EXAMPLE- EVERY 4 HOURS AS NEEDED)

ANTICIPATED NUMBER OF DAYS TO BE ADMINISTERED AT SCHOOL _____

I hereby give my permission for _____ to take the medication listed above at school. I understand that it is my responsibility to furnish the medication in the original container, marked with the student's name. I understand that if the medication is in liquid form, it is my responsibility to furnish an appropriate measuring device which will provide an accurate measurement of the required dosage. I further understand that the school nurse or any school employee who administers the medication to my student in accordance with these written instructions shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

Date

Signature of Parent/Guardian

Daytime phone