NON-PRESCRIPTION MEDICATION
ADMINISTRATION CONSENT FORM
Required for Non-Prescription Medications
At School for **10 or Fewer Consecutive Days**

Dear Parent/Guardian:

To comply with our school's medication policy, please complete this form and return it to your child's school. This information will help us to be sure that the medication is given at the right time and in the proper dosage. **In order to comply with state regulations, the medication must be sent to school in its original container along *with this completed form*.** If this complete information is not provided, the school staff will not administer the medication.

Supplies of nonprescription medication (Tylenol, Midol, aspirin, etc.) will not be kept at school for occasional use by the student throughout the year, unless a physician authorization form is received.

If you have any questions, please contact the school office. Thank you for your cooperation.

Date__________________ School____

Student Name____Grade________

Name of Medication_______________________________ **Dose**________________

Days and Times of Administration____

Reason for Use____

Side Effects____

I, the parent/guardian of the above named student, have read the school's medication policy and request the medication listed above be administered to my child at school. I understand that qualified, designated person(s) will be administering the medication. I will notify the school immediately if there is a change or cancellation of the medication.

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Parent/Guardian Signature