

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION AT SCHOOL

- Please complete a separate form for each additional non-prescription medication not already listed in the enrollment/re-enrollment information with permission to give.
- All medications must be hand delivered by an adult to the school nurse or main receptionist if the nurse is not available. Do not send medication with a student.
- If the medication dose requested exceeds the manufacturer's recommendations and/or administration of medication will be greater than 10 consecutive days, a Licensed Health Care Provider must complete the Authorization for Prescription Medication at School form.
- Please pick up all medications prior to the last day of school. Any medication not picked up will be destroyed.

PLEASE PRINT

SCHOOL YEAR _____

STUDENT'S NAME _____ HOMEBASE TEACHER _____

NAME OF MEDICATION _____

REASON FOR GIVING MEDICATION AT SCHOOL (Please be specific):

DOSAGE/AMOUNT OF MEDICATION TO BE GIVEN _____

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL _____

DATE TO START MEDICATION _____ DATE TO STOP MEDICATION _____

EXPIRATION DATE OF MEDICATION _____ (Expired medication will not be given at school.)

POSSIBLE SIDE EFFECTS _____

Parents Please Read Carefully:

- I understand that all medication will be provided by me in the original container with manufacturer's label and labeled with my child's name.
- I will notify the school if the medication is discontinued or the dosage has been changed.
- Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child.
- The first dose will be given at home so that I can monitor adverse reactions.
- I am responsible for replacing medication before the expiration date.

PLEASE PRINT PARENT/LEGAL GUARDIAN NAME _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____