School Health Services
OTC/Non-Prescription Medication Administration at School

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:

- **Deliver this medicine to school 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 medication dosage does not match the instructions on original container, a healthcare provider order is required.**
- **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:_____