



Non-Prescription Medication Administered at School

School: _____

School Year: _____

Student Name: _____ D.O.B.: _____

Student Address: _____

Grade/Class: _____

Name of Medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for Medication: _____

Form of Medication: _____ Tablet _____ Liquid _____ Inhaler _____ Nebulizer _____ Other

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported to parent or doctor: _____

Doctor's Name: _____ Phone: _____
Printed Name

I give permission for my child to receive medication at school according to the school district policy and agree to:

- Assume responsibility for safe delivery of the medication in its original container to the school
- Notify the school immediately if there is any change in the use of this medication
- Have a new medication form completed if dosage or instructions change
- Notify the school of changes in healthcare provider

I hereby release from liability, and in addition agree to indemnify, all school employees, the Board of Education and School Health Services for damages or injury resulting from the use, misuse or nonuse of such medication except as such Board, School Health Services or its employees are grossly negligent or engage in wanton or reckless misconduct.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____

Alternate phone number in case of emergency: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****