



## PARENT / GUARDIAN REQUEST FOR NON-PRESCRIBED MEDICATION BY SCHOOL PERSONNEL

Student Name ..... Date of Birth .....

Physician's Name .....

Address .....  
Street City State Zip

Parent / Guardian Name ..... Phone .....

I hereby request and give my permission to the principal or a designee (nurse, secretary, teacher, or another responsible trained person) to administer the following medication to my child:

Name of Drug ..... Dose ..... Times .....

Reason for drug to be administered at school .....

Beginning date of this request ..... Expiration date of this request .....

.....  
Parent / Guardian Signature Date

***Parents must send medication to the school in its original container.***

Note: The parent/guardian of the child must assume responsibility for informing the principal or a designee (nurse, secretary, teacher, or another responsible trained person) of any change in the child's health or any change in the non-prescribed medication. Any change to the above non-prescribed prescription (dosage or administration) will require the completion of a new form.

.....  
School Official's Signature (Acknowledging Receipt) Date

***Revised 06/2021***