

Authorization to Administer Non-Prescription Medication

Student _____ Birth date _____

School _____ Grade _____ School Year _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Daytime Phone (_____) _____ Daytime Phone (_____) _____

Cell (_____) _____ Cell (_____) _____

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Medication Consent:

I give permission for my son/daughter to receive the medication listed according to the direction stated below from a school staff member appointed by the school principal. Self-administration of non-prescription medication is not permitted. I agree to hold the New Berlin School District harmless in any and all claims arising from the administration of this medication. I agree to notify the school in writing at the termination of this request or when any change in the above orders are necessary.

I understand that it is my responsibility to:

- Supply a properly labeled bottle of medication in its original labeled packaging. I understand that the instructions for administration may not exceed the manufacturer's recommended dosages. The medication **MUST** be stored and taken in the health room or school office.
- Replace the supply of medication when needed. Expired medication will not be administered to students.
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year or will be disposed of.

Parent/Guardian Signature _____ Date _____

Non-Prescription Medication to Be Given at School

Name of Medication: (generic and trade)		
Reason for medication:		
Dosage of Medication:	_____ mg / cc / tsp _____ drops / puffs	Form: <input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Ointment/Cream <input type="checkbox"/> Ear/Eye/Nose Drops <input type="checkbox"/> Inhaler
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Eyes <input type="checkbox"/> Ear <input type="checkbox"/> Nose <input type="checkbox"/> Topical <input type="checkbox"/> Rectal <input type="checkbox"/> Other _____	
Time to be given:	<input type="checkbox"/> As needed - Describe frequency & symptoms for which medication should be given: _____ <input type="checkbox"/> May be repeated in _____ minutes/hours. (time)	