Grade: _____

High School

SHIOCTON SCHOOL DISTRICT HEALTH SERVICES

Nonprescription Medication

Parent(s)/Guardian Authorization Form

Parent/Guardian- Please fill out this form if you wish your child to have NONPRESCRIPTION medication as needed at school. High School students may keep such medication as Tylenol, Sudafed, etc. with them as long as they have parent permission and understand that they **may not share** medication with anyone or abuse the privilege or it will be revoked. Please note that the school does not supply any medication and **all medication kept in the health office must be brought in by an adult.**

_____has my permission to take the following

NONPRESCRIPTION medication for the 20___/20___ school year.

ALLERGIES ? Yes / No If yes, to what? _____

Type of reaction _____

- Medication Name _____Dosage_____

Reason for medication _____

Student may keep medication with him/her at school Yes / No ** Please circle**

- Medication Name _____Dosage_____

Reason for medication _____

Student may keep medication with him/her at school Yes / No **Please circle**

PARENT:

I request that my child be assisted by designated school personnel in taking the medication described above at school as authorized by me and my physician. Specific questions/concerns may be communicated to the physician by the Registered Nurse serving the school.

I further agree to hold the Shiocton School District and all employees harmless in any and all claims arising from the administration of this medication at school.

As the parent or guardian of the above mentioned student, I will keep the school district aware in writing of any changes in the medication(s) profile or health concern of my child.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

NOTE: Any change in medication will require a new form and will expire at the end of each school year.