Grade: _____________

SHIOCTON SCHOOL DISTRICT HEALTH SERVICES
Nonprescription Medication
Parent(s)/Guardian Authorization Form

____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 ____

Special Instructions ____

♦ Medication Name ___________________________________Dosage____________________

Reason for medication ____

Special Instructions ____

♦ Medication Name ___________________________________Dosage____________________

Reason for medication ____

Special Instructions ____

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 schools.

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.