Non –Prescription (Over-the-Counter) Medication Permit

To be completed by parent / guardian.

Name of Student: _____ Birth date: _____

Student Address: _____

School Building: _____Grade: _____

The following non-prescription medication may be given to my child:

Medication: _____

Dosage: _____

Under **what conditions** to be given: _____

Please Note:
*The medication must be in the original container and properly labeled. (Not in plastic bag.)
*The medication will be given as prescribed on the manufacturer's label.
*Student's name must be clearly visible on the container.
*Non-Prescription (over-the-counter) medications are not to be kept by the student.

I request designated school personnel to administer the medication as instructed and will notify the personnel if the medication is changed or eliminated. I understand it is the student's responsibility to request the medication. I agree to hold designated school personnel and the Board of Education free from all responsibility for ill results of such medication.

Parent / Guardian name Printed: _____ **Date**: _____

Parent / Guardian Signature: _____

Phone #'s to reach you: _____ _____ _____

MEDICATION LOG (for Band Nurse use)

Date	Time	Amt.	Reason	Signature	/	Date	Time	Amt.	Reason	Signature