SAU #30

Woodland Heights School

**Permission to Administer Non-Prescription Medication**

Student Name: Date of Birth:

Teacher/Grade:

**Medication Name:**

**Dose:**

**When to administer:**

**Reason for taking medication**:

I request that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student) be assisted by the school nurse, principal or designee in receiving the non-prescribed medication during school hours.

I, the parent/guardian, authorize the school administrator to direct members of the school staff to assist this child in taking oral medication and agree that I will not hold liable any member of the school staff or any individual of official capacity who is directed by me and the school administrator to assist this child in taking said medication.

The parent, or a responsible adult, will be responsible for transporting medication to school. The medication must be in its original container, properly labeled with the students name and date of birth. Non-prescribed medication cannot be given for more than three consecutive days unless a physician’s note is provided.

Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_