

**PARENT'S REQUEST FOR THE ADMINISTRATION OF NON-PRESCRIPTION MEDICATION AT SCHOOL**

**To be completed by parent or guardian:**

I request the school nurse, building principal or designee to administer the non-prescription medication named below to my child. I will hold the school personnel harmless for the administration of the medication described below because they are not legally obligated to administer medication to my child.

Student's Name: \_\_\_\_\_

Student's School: \_\_\_\_\_

Student's Address: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage to be administered: \_\_\_\_\_

Times or intervals at which each dose should be given: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Date administration is to begin: \_\_\_\_\_

Date administration is to end: \_\_\_\_\_

Name and phone number of the physician to be called in case of an emergency:

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of Parent/Guardian

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

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**To be completed by School Personnel:**

Nurse's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Designee's signature: \_\_\_\_\_ Date: \_\_\_\_\_