PERMISSION FORM FOR NON-PRESCRIPTION MEDICATION

Attached to this you will find the form for "Non-Prescription" medications.

*This form must be complete and signed by the parent for over-the-counter medications.

*All medications must be delivered directly to the school office by a parent or guardian.

*The medication must be in the original container with the students name on it.

*Any unused medication unclaimed by the parent will be destroyed by school personnel at the end of the school year.

*Under NO circumstances are children to transport any medications to or from school on the bus.

**The term "medication" includes, but is not limited to, aspirin, cough drops, cough syrup, and any other over-the-counter medications.

PLEASE DO NOT ASK SCHOOL PERSONNEL FOR ANY EXCEPTION TO THESE RULES.

Algonac Community Schools

PERMISSION FORM FOR NON-PRESCRIPTION MEDICATION

School: _____ Date received by school: _____

Student: _____ DOB or age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by parent/guardian

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

☐Tablet/capsule ☐Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other_____

Instructions (Schedule and dose to be given at school): **Dosage:** _____ **Time:** _____

Start: ☐Date form received Other dates: _____

Stop: ☐End of school year Other date/duration: _____

Restrictions and/or important side effects: ☐None anticipated ☐Yes, Please describe: _____

Special storage requirements: ☐None ☐Refrigerate ☐Other: _____

This student is both capable and responsible for self-administering this medication:

☐No ☐ Yes (Supervised) ☐Yes (Unsupervised)

This student may carry this medication: ☐No ☐Yes

Please indicate if you have provided additional information: ☐On the backside of this form ☐As an attachment

Date: _____ Signature _____

Physician's name: _____
Address: _____
Phone No. _____

To be completed by parent/guardian

☐ I request that (name of child) _____ receive the above medication at school according to standard school policy, and I understand it needs to be delivered to school by an adult and the medication must be in the original container with directions

☐ I request that (name of child) _____ be allowed to self-administer this medication at school according to school policy

Date: _____ Signature: _____ Relationship: _____

White: Principal Copy Yellow: Parent Copy c \forms\med non presc