

STOW - MUNROE FALLS CITY SCHOOLS

NON-PRESCRIPTION MEDICATION ADMINISTERED AT SCHOOL

Attach Student Picture if Available
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School: _____

School Year: _____

Class/Grade: _____

Student Name: _____ Date of Birth: _____

Student Address: _____

Name of medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for medication to be administered: _____

Form of medication: Tablet Liquid Other

Start Date: _____ Stop Date: _____

Special Instructions: _____

Potential adverse reactions to be reported to parent or physician: _____

Physician/Healthcare Provider Signature: _____Physician/Healthcare Provider Name: _____ Phone: _____
(Print Name)Parent/Guardian: I give permission for my child to receive this medication at school according to the School District policy.

I agree and am responsible to:

- Deliver this medicine to school in its original container.
- Tell the school as soon as possible if there is a change in the use of this medicine.
- Complete a new medicine form for this medicine if there are dose changes. If medication dosage does not match the instructions on original container, a healthcare provider order is required.
- If this medication is needed for greater than four (4) consecutive days, a healthcare provider order is required.

I agree for my child's healthcare provider to talk with the school or any school staff person about this medication if needed. No other part of my child's medical health will be discussed. When my child receives this medication I will be notified.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____ Emergency Alternate Phone: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

Clinic Use Only: Date form received: _____ Date medication received: _____ Form Complete (Y or N): _____
Notes: _____ Date Form Complete: _____