Hastings Schools Health Services

Parental Request
for Administration of a
NON-PRESCRIPTION MEDICATION

Dispensing FDA approved over-the-counter medications at school requires:
1) *Written authorization from parent/guardian*
2) *The medication supplied in the original container by the parent.*

If more than 10 doses of medication to be given throughout school year, physician authorization must be obtained.

Student Name:____________________ **Grade:**________ **Birthdate:**__________

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I authorize designated school personnel to dispense to my child the following medications. I release school personnel from liability in the event any reaction results from the medication.

Medication Name:____________________ **Dose:**________ **Frequency:**__________

For treatment of:__________________ **Special Instructions:**____________________

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For treatment of:__________________ **Special Instructions:**____________________

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For treatment of:__________________ **Special Instructions:**____________________

If necessary school personnel may request additional information from the physician regarding this medication.

Parent/Guardian Signature:____________________________ **Date:**____________

Daytime Phone:____________________

☐ **I authorize my child to bring this medication home at the end of the school year.**

Kennedy	McAuliffe	Middle School	Pinecrest	Senior High
1175 Tyler	1601 W. 12th	1000 11th St. W	975 W. 12th	200 General Sieben
438-0815	437-6607	437-3045	438-0836	480-0301
fax:438-0613	fax:438-0617	fax: 438-0707	fax:438-0614	fax:480-8126

Date returned to Health Office________ Entered on computer_______ Staff signature___________ Med available_____