



Permission for Non-Prescription Medication

School District: Union County

For school use only:

- Routine
- PRN (As needed)
- Start Date: _____

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits of what is printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

Child's Name _____

Date of Birth _____

Name of School _____

Grade _____

Is your child allergic to any food, medicines, or other items? Yes No
If yes, list allergies.

Name of medication to be given at school:

Reason for medication:

Amount of medication to be given:

Time of day medication to be given at school:

Note any special storage requirements:

Refrigerate Other:

Estimated number of days medication needs to be given at school (choose one):

_____ days _____ weeks
 until the end of the current school year

Does your child take any other medications at home or at school? Yes No
If yes, what are the medications?

Child's Health Care Provider's Name and Address:

Office Phone Number:

Office Fax Number:

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to share information about this medication and my child's health with the school nurse or school administrator. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if any of my child's medications change.

Signature of Parent / Guardian _____

Date _____

Print or Type Name of Parent / Guardian _____

Day Phone Number _____