

Germantown School District

PARENTAL REQUEST FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

Date: _____ **School:** _____

_____ is in need of medication during school. I hereby give permission to school staff designated by the principal to administer the below listed medication (one medication per sheet). It is my understanding that medication will be administered under the general supervision of a district designated health care professional.

Parent/Guardian Initials _____

Name of Medication: _____ Reason for Medication: _____

Dosage: _____ Time of Administration: _____

How to be given (i.e. with water, with food): _____

Physician: _____ Clinic: _____ Phone: _____

I also give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding medication administration.

Parent/Guardian Initials _____

I also give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

Home Phone: _____ Work Phone: _____

Parent/Guardian Initials _____

I will notify the school in writing at the termination of this request for medication administration, or of any change in directions of administration. In the event that I revoke consent for medication administration or discontinuance due to physician orders, I understand that a new Parental Request for Administration of Medications would need to be completed to reinitiate this request.

Parent/Guardian Initials _____

All non-prescription medication will be supplied in its original manufacturer's container. The medication is to be delivered to the school office by parent or parent designated adult.

Parent/Guardian Initials _____

I understand that no medication will be administered by the school without full compliance of the above stated terms and conditions.

Parent Guardian Signature

Date