Mapleton Local Schools

MEDICATION ADMINISTRATION REQUEST FORM

NON-PRESCRIPTION MEDICATION FORM
Up to 2 over-the-counter medications per form
Not for prescription medications

Student Name: _____ School: _____ Grade: _____

Address: _____ Date of Birth: _____

_____

TO BE COMPLETED BY PARENT/GUARDIAN

Name of Medication _____

Reason for Medication _____

Dosage & Route of Medication _____

Time(s) each of is to be administered _____

Start Date _____ Stop Date _____

Name of Medication _____

Reason for Medication _____

Dosage & Route of Medication _____

Time(s) each of is to be administered _____

Start Date _____ Stop Date _____

I hereby request and give permission to the designated school employee to administer the medication listed above to my child as directed for the OTC medication and I agree:

- To assume responsibility for safe delivery of the medication to school in its original labeled container.
- That above instructions are correct as directed for the OTC medication.
- To notify the school in writing of any changes in medication.
- Hold the board of Education, its officials, and its employees harmless from all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly for this authorization.

_____

Parent/Guardian Signature Date

_____

Printed Name Phone Number