Unity School District

Parental Permission to Administer NON-PRESCRIPTION MEDICATION

***PARENTS MUST SUPPLY ALL MEDICATIONS IN THE ORIGINAL CONTAINERS AND MANUFACTURER'S DOSING RECCOMENDATIONS.

#1 **STUDENT/ MEDICATION INFORMATION**

School Year or Effective Date: _____ School: _____ Grade: _____

Student Name: _____ Birthdate: _____

Medication #1: _____ Dosage: _____Time: _____Route: _____

Reason for Medication: _____

Medication #2: _____ Dosage: _____Time: _____Route: _____

Reason for Medication: _____

Medication #3: _____ Dosage: _____Time: _____Route: _____

Reason for Medication: _____

Note requirements: *Completed* medication information section (1) and ***signed Parent Consent #2 below. Dosage must match recommended dosage on package.

#2 **PARENT CONSENT**: Complete above for **EACH MEDICATION** at school

I request that this medication be administered at school by designated employee(s) and release said employee(s) of liability. I will supply the medication in its original container and bring to the office. I will notify the school in writing of any medication changes. This consent is in effect for the school year unless otherwise indicated. By signing below, I am consenting that my child has taken the above medication before without any signs or symptoms of an allergic reaction.

Date _____ Parent/Guardian Signature _____

Phone (home) _____ (work) _____(cell) _____

Fax: 715-825-4430 Phone: 715-825-2101